St Margarets Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 October 2016 and was unannounced. St Margarets Residential Care Home provides accommodation for up to 18 people, including people living with dementia care needs. There were 15 people living at the home when we visited. The home is based on two floors, connected by a stairway with a stair lift. Three bedrooms are shared double rooms and 12 bedrooms are for single occupancy.

The home had 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 provider is registered as a partnership. Providers are required to notify us of any changes affecting the partnership. However, they did not notify us of the death of one of the partners and the appointment of a new partner in 2013. Providers are also required to display their CQC performance rating. Whilst they had displayed this on the premises, they had not displayed it on their website, as required.

At our previous inspection in August 2015, we found staff were not following legislation designed to protect people's rights. We asked the provider to write to us detailing how they would become compliant with the regulations. They did not do this and we found they had not taken appropriate action to ensure people's rights were protected. Staff were continuing to make decisions on behalf of people but had not assessed whether these were necessary or in the best interests of people.

There was a quality assurance process in place, but this was not always effective in maintaining and improving the quality and safety of the service. Although people felt the home was run well, staff told us they did not work well together and suffered from low morale. This had affected communication between them to the detriment of people living at the home.

We found people's safety was compromised in some areas. For example, fire safety checks had not been completed for the previous three months, so the provider was unable to confirm that they were operating correctly.

People's medicines were not always managed safely as some medicines were not stored appropriately; information was not always available to inform staff when to administer 'as required' medicines; and the competence of staff to administer medicines was not assessed regularly, as recommended by best practice guidance.

Whilst there were sufficient staff to meet people's needs at most times, this was not always the case at weekends. However, senior staff said there were plans in place to address this.

Staff were not supported to undertake appropriate training to ensure they had the necessary skills to meet

people's needs. Some staff who administered medicines had not their training refreshed for over three years; practical training in supporting people to move safely had not been refreshed for over a year; the food hygiene certificates of staff who prepared meals for people had expired; and induction training for new staff was not robust.

People said they were satisfied with the meals provided, but we found some people's dietary needs were not always met. Menus were not available and meals were not planned to help ensure people received a healthy, balanced diet; and people who required a low-sugar diet did not always receive it. Although most people were weighed regularly, staff did not take appropriate action when people were found to have lost weight.

People told us their needs were met in a personalised way, but we found for some people this was not always the case. The care needs of a person with a catheter were not always met as staff did not monitor it effectively and their care plan did not provide supporting information. Similarly, the care plans for three people with diabetes did not provide enough information to enable staff to support them effectively; as a result, staff had not taken action when one person's blood sugar levels were found to be particularly high.

Activity provision was limited and activities had not been tailored to meet the individual interests of people. However, work was on-going to improve this.

People, their families and healthcare professionals said they were satisfied with the care provided to people and felt their needs were met. Staff supported people to access healthcare professionals and provided supporting information if they were admitted to hospital. Staff were skilled at communicating with people living with dementia and people were supported and encouraged to make choices about how and where they spent their day.

The process used to recruit staff was safe. Staff knew how to protect people from the risk of abuse. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions.

People told us they were cared for with kindness and compassion by staff who interacted with them positively. Their privacy and dignity were protected at all times. People were encouraged to remain as independent as possible and they (or their family members) were involved in planning their care.

The provider sought and acted on feedback from people. People felt senior staff were approachable and any concerns would be dealt with. However, information about the provider's complaints procedure was not always made available to people.

We identified several breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's safety was compromised as fire safety checks had not been conducted for the previous three months and staff were not consistently knowledgeable about what to do in the event of a fire.

People's medicines were not always managed safely and the competence of staff to administer medicines was not checked regularly.

There were not always enough staff to meet people's needs, particularly at weekends, although there were plans in place to improve this. The process used to recruit staff was safe.

Other risks to people were managed effectively and people were supported to take risks that helped promote their independence.

Is the service effective?

Requires Improvement

The service was not always effective.

During the care planning process, senior staff did not always follow legislation designed to protect people's rights. However, staff did seek verbal sought consent from people before providing care and support.

Staff did not receive appropriate induction, training, supervision or appraisal to support them in their role.

People's dietary needs were not always met and staff did not always take appropriate action when people experienced unplanned weight loss. However, people did receive support to eat and drink when needed.

People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They protected people's privacy and dignity at all times.

People were encouraged to remain as independent as possible and were involved in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain enough information to enable staff to provide personalised care that met people's individual needs. Activity provision was limited and was not tailored to people's interests and need for mental stimulation.

People were supported and encouraged to make choices about every aspect of their lives. Staff provided examples of where they had responded to people's changing needs.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints procedure in place, although this was not made available to people.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not updated CQC about changes affecting their registration. They had not acted on feedback provided in the last CQC report or taken action to address a breach of regulation. They had not displayed the CQC rating on their website, although they had displayed it on the premises.

People felt the home was run well, although staff said their morale was low and they did not work well as a team. This had affected communication which meant information about people's health was not always shared between staff.

There was a quality assurance process in place, although this was not always effective. There was a duty of candour policy in place, but this was not always followed fully.

St Margarets Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was also carried out to check whether improvements had been made from the August 2015 inspection.

This inspection took place on 11 October 2016 and was unannounced. It was conducted by one inspector.

Before the inspection, the provider completed 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people living at the home, two family members, a community nurse and a visiting care worker from another company who supported a person on a one-to-one basis. We also spoke with the registered manager, the deputy manager, two supervisors and three care staff. Following the inspection we received feedback from a doctor and a social care practitioner from the local safeguarding and quality team who had regular contact with the home.

We looked at the care plans for two people in depth, and aspects of care plans for a further seven people. We looked at staff training records, two staff recruitment files, duty rosters, records of complaints, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. 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.

Requires Improvement

Is the service safe?

Our findings

People's safety was compromised as fire safety checks were not completed regularly. Since the last inspection, in August 2015, alarms had been placed on external fire exits, so staff would know if someone had left the building unattended. However, not all staff were aware of the action to take in the event of a fire. They told us they no longer had regular fire drills and fire training which they had had in previous years. One staff member said they would try to put out the fire, while others said they would not; they also said they would start to evacuate people from the building, but other staff said they would move people within the building. One staff member told us they had never heard the fire alarm, so may not recognise it if it activated; and another said they did not know where the assembly point was. The provider's policy required staff to complete a variety of fire safety tests on a weekly and monthly basis. However, records showed that no fire safety checks had been conducted during the previous three months. Therefore, the provider was unable to confirm that fire safety systems and equipment were operating effectively to ensure people's safety in the event of a fire.

The failure to operate effective systems to assess, monitor and mitigate risks to the health, safety and welfare of people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the provider had responded to other recommendations made in a recent fire safety risk assessment to improve the fire safety arrangements at the home. An emergency bag and file had been prepared, containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support people would need if they had to be evacuated in an emergency.

People's medicines were not always managed safely. Some people were prescribed medicines on an "as required" (PRN) basis. These included pain control medicines and sedatives. Detailed information was available for staff to know when, and in what circumstances, to give some of these medicines to people, but there was no information available for two of the medicines. For example, information in the medication administration records (MAR) about one medicine instructed staff to administer 'one tablet when required', but there was no further information detailing how many tablets could be given over a 24 hour period, or the recommended time interval between doses. However, whilst there was a risk that the person might be given too many tablets, records showed this had not occurred.

A box of medicine that was to be used by community nurses in the event that a person had an epileptic seizure, was being stored, but had not been recorded in the person's medicine records. Had it been needed in an emergency, staff checking the person's records would not have known that a supply of the medicine was in stock and available for use. Therefore attending nurses or emergency services may not have been given immediate access the medicine, which would have delayed the treatment for the person.

Some medicines are subject to additional controls by law and require secure storage that meets a high specification. We saw the storage arrangements for these medicines did not comply with the enhanced

security requirements, so could be vulnerable to misuse.

Most staff had not received refresher training in the safe administration of medicines since their initial training, which for some staff members was more than 10 years ago. Staff did not have access to, and were not aware of, the latest guidance published by the National Institute for Health and Clinical Excellence (NICE) on the safe management of medicines in care homes. There was no process in place for the provider to regularly check that staff administering medicines were still competent to do so, as recommended by NICE guidance.

The failure to ensure medicines were managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, people told us they received their medicines when they needed them. One person said, "I get all my medication; if I needed something for a headache, I'm sure I'd get it." Daily and weekly check sheets were in place to identify any gaps in people's MAR charts and we saw these had been used to prompt staff members to complete the MAR charts fully. There was also a suitable system in place to help ensure topical creams were not used beyond the manufacturer's recommended 'use by' date.

At times, there were insufficient staff to meet people's needs effectively. People told us they were usually enough to meet their individual needs. One person said, "There is always someone about if you need them." Another person told us there were "plenty" of staff. However, a family told us it was "hectic" at times and staff told there were times, usually at weekends, when only two staff were on duty. At these times, they said they struggled to care for people effectively. For example, two people needed two staff members to support them into and out of bed. When both staff members were engaged with these people, there were no other staff members free to respond to people's call bells or supervise people in communal areas of the home.

The registered manager told us a third member of staff (often themselves) was always available to be called, but accepted that they were not always "on the floor" at these times. The deputy manager said, "It's gone on too long with shortages at weekends. I agree that [the two staff members on duty] should not both be with [one person] for more than a few minutes, as other people are unsupervised." They told us they had recently recruited an additional staff member who would be able to provide additional cover at weekends to help ensure three staff members were always on duty and people's needs were met consistently.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The registered manager carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

People said they felt safe at St Margarets. One person told us, "I feel very safe; nothing worries me about the care here." Another person said, "Nothing troubles me; everyone treats me okay." Staff were aware of their responsibilities to safeguard people from the risk of abuse. They knew how to identify, prevent and report abuse. A member of the local safeguarding and quality team told us they were confident staff would engage with them if they had any concerns. One person was potentially at risk of abuse from family members; all staff were aware of the concern and the action they should take to keep the person safe. The registered manager had worked closely with the person's care manager to develop a suitable strategy to protect the person from harm.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to mobilise on their own, whilst remaining close by, in

case they needed additional support and allowed them to travel at their own pace.

One person had had surgery to their wrist and staff encouraged them to use the stair lift to go upstairs, so as not to put unnecessary strain on their wrist by holding the bannister rail. When mobilising around the home, staff gave the person instructions to stand correctly and not put too much weight on their arm. The person responded positively to this encouragement and thanked staff for their concern.

Special chair lifters had been fitted to some dining room chairs. These allowed the chairs to be lifted slightly so people could be positioned close to the table without putting any stress on them or the staff member. Two people needed to use equipment to support them to transfer between chairs and their bed. Staff described how they always operated this in pairs and in accordance with the manufacturer's guidance.

Other risks were managed effectively. For example, some people were at risk of developing pressure injuries and had been given special pressure-relieving cushions and mattresses to reduce the risk. These were used when needed and the mattresses had been set to the correct setting for each person. Other people were at risk of falling and we saw soft mats had been placed by their beds to protect them if they fell out, in addition to devices to monitor their movements so staff would know if a person had moved to an unsafe position.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in August 2015, we identified that staff did not always follow the Mental Capacity Act, 2005 (MCA) or its code of practice and this was a breach of Regulation. We issued a requirement notice and asked the provider to send us an action plan detailing how they would become compliant with the regulation. At this inspection we found appropriate action had not been taken and people's rights were still not being protected.

Senior staff did not have a good understanding of the MCA and how to apply it during the care planning process. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

During the care planning process, senior staff had made decisions on behalf of people, including decisions to deliver personal care, to administer medicines and to use equipment to monitor people's movements. In none of these cases had staff conducted assessments of the person's capacity to consent to these interventions or completed best interests decisions. This meant the registered manager was unable to confirm that the decisions were made in conjunction with people, were least restrictive options or had been taken in the best interests of people.

Some people's care plans included a 'consent to care' form. Two people, who had capacity to make decisions, had signed these forms to show their agreement with the care that was planned. However, in two other cases the forms had been signed by a family member. Staff had not checked that the family members had authority to act on behalf of their relative. They told us they thought a person's next of kin was always able to do this, which is not the case. This demonstrated a lack of understanding about who can give lawful consent and when.

The continuing failure to ensure that care and support were only provided with the consent of the relevant person was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we observed staff did seek verbal consent from people before providing them with care or support. A staff member told us, "We always ask people [before providing care and support]. You can see by their expressions and how they react if they are happy for you to go ahead, once you know them and their character."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being

met. We found the provider had appropriate policies and procedures in place and DoLS applications had been authorised for two people. However, the registered manager and senior staff were not aware that a condition had been attached to the DoLS authorisation for one person. Neither did they have a good understanding of a court ruling that clarified the circumstances in which a DoLS was required. Care staff told us most people were subject to continuous supervision and control and would not be permitted to leave the home unsupervised. We discussed this with the registered manager who agreed to seek advice from the local authority and review the need to make further DoLS applications.

People and their families told us they felt the service was effective, that staff understood people's needs and had the skills to meet them. One person said of the staff, "They look after me well." Another person told us, "[Staff] do everything for me. Nothing is too much trouble and they know what they are doing." A family member told us, "The care is very good. [My relative] looks well cared for." A visiting community nurse said, "The care is very good. I get a good feeling about the home. [Staff] want to make sure people are cared for properly."

Although people felt staff were skilled, we found staff were not always supported to undertake regular training to properly equip them for their role. For example, staff training records showed most staff had not completed practical training in supporting people to move safely since January 2015. The provider's policy required staff to complete this training every year. A new staff member told us they had never received practical training in supporting people to move. They said they regularly used a hoist to support two people, but had received no training in its use, other than from colleagues. Therefore, staff may not have been following current best practice guidance.

The provider's policy also required staff who administered medicines to undergo refresher training every three years, but we saw this had not occurred. Most staff assisted in the preparation of meals for people. However, their food hygiene certificates had expired in 2015. This meant they had not received recent training and may not have been following best practice guidance, in relation to food hygiene, when preparing meals for people.

The registered manager told us staff with previous experience of care received an induction when they started work at the home and worked alongside experienced members of staff until they were confident to work unsupervised. However there was no clear procedure in place to make sure all key topics were covered during induction; and there was no assessment process to decide when staff were sufficiently competent to work alone. We discussed this with the registered manager, who described the arrangements as "a bit hit and miss".

People were not cared for by staff who were supported in their role through supervision and appraisal. These are processes which provide opportunities for management to meet with staff, feedback on their performance, identify any concerns, offer support and identify training needs. This was highlighted as an area for improvement at the last inspection but had not been addressed. Staff had been asked to complete a performance self-assessment form, but only four had done so and these had not led to any meetings with management. Most staff told us they did not feel supported in their role. For example, one said, "My training is not up to date. I've had no supervision or appraisal. I'm never asked about how I'm doing and what training I need."

The failure to ensure that staff received appropriate support, training, development, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff had completed dementia awareness training and we saw they were skilled at communicating with people living with dementia. They spoke calmly, bent or knelt down so they were at the person's eye level, and engaged the person. When asking questions, they used simple language, offered choices in ways people could understand and gave them time to respond.

Arrangements were in place for staff who did not have experience of care to complete training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us they had also completed this recently, in order to give them an understanding of the standards. A senior member of staff was being supported to obtain a level five qualification in health and social care. This would help support them in their supervisory role. Other staff had previously obtained vocational qualifications relevant to their roles.

Menu planning was not used to help ensure people received adequate nutrition. Senior staff told us a menu used to be advertised, but this was being changed to an 'autumn menu' which was not yet available. The home did not have a cook, so meals were prepared by care staff. They said in the absence of a menu, it was a case of "whatever's in the freezer". The lack of menu planning meant the provider was unable to confirm that people were receiving a balanced diet over a period of time. A choice of meals was not proactively offered, although people told us they could ask for an alternative if they did not want the meal of the day. For example, one person said, "They would make me something else if I didn't like [the meal of the day], but I always do."

The meals provided did not always support people's dietary needs. Three people were diabetic and their care plans specified the need for a low-sugar diet. However, staff were not clear about what a low-sugar diet was and there was no information about this in people's care plans. At lunchtime, everyone had the same dessert, which was not low in sugar. A senior staff member told us they had low-sugar options, such as yoghurts, but these were not always offered to people.

Staff monitored the weight of most people each month but did not always take action when unplanned weight loss was identified. Two people had lost a significant amount of weight in recent months, yet action had not been taken to address this. Their nutritional care plans had not been updated and contained limited information about the support they needed. No effort had been made to fortify or review their diets or to seek specialist advice. People who could not weight bear were unable to be weighed as the service only had access to stand-on scales. A senior staff member said they used to monitor the body mass index (BMI) of these people using a nationally recognised tool. However, the only staff member who had been trained to do this had left the service, so people had not had their BMI checked for nearly a year. We discussed this with a senior staff member, who agreed that the monitoring of people's diet and weights was an area for improvement.

The failure to ensure people's dietary needs were met in an appropriate way that reflected their needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were satisfied with the quality of the meals. One person said, "We get enough to eat and have a reasonable choice." Another person described the food as "most enjoyable; just to my liking" and said there was always "plenty to drink". They added: "If it's not on the menu, [staff] walk down to the town to get it for me. For example, they get spring water in specially for me; it's lovely and cold and now everyone has it." A family member told us, "If I take [my relative] out, they hold back her meal for her, which is good."

People were support appropriately to eat and drink. We saw a range of drinking vessels suited to people's individual needs. One person required full support with their meal and we saw this was provided on a one-to-one basis in a dignified way. Two other people needed their meals to be cut up. This was done in front of them so they could recognise the meal before it was cut up.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person said, "There's a doctor on call and we don't wait long if we need to see one." A doctor told us, "[Staff] follow advice and listen. My advice may not always be appropriate and they are happy to have a discussion about it to decide what is most appropriate [for the person concerned]."

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. One person said, "[Staff] treat me well. They're fantastic; they're more like friends." They said the registered manager was "on the same wavelength; we have quite a giggle. Nothing is too much trouble for her." A visiting nurse said of the staff, "They care about people and want the best for them." A doctor who had regular contact with the home told us, "[The staff] look after people with some very advanced dementias and they are very caring [with them]."

We observed positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. People and staff showed mutual affection towards one another. They were relaxed in each other's company and staff used touch appropriately to greet or comfort people. They showed interest in people by asking how they were and whether they needed any additional support. One person was recovering from surgery and each member of staff that greeted them in the morning asked how they were feeling, whether they had any pain and how their recovery was progressing.

When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. They also spent time kneeling next to people, so they could engage with them at eye level.

People's privacy and dignity were protected. When people were supported to use the bathroom, staff gave them the option of remaining with them or leaving them, to give them privacy, and returning later. When people received personal care, staff made sure doors were closed. Bedroom doors had a notice on them reminding staff to "Stop! Think dignity". Each person's care plan had information about ten key ways to maintain a person's dignity as a reminder to staff. A senior staff member told us they reinforced these principles to care staff at every opportunity. They said, "It's my big thing, dignity; I nag them all the time."

Before entering people's rooms, we saw staff knocked, waited for a response and sought permission from the person before going in. When the registered manager needed to discuss a person's mental health with staff, they took them into a private office so their conversation could not be overheard. Confidential information, such as care plans, was kept securely and only accessed by staff authorised to view it.

Staff described other practical steps they took to preserve people's dignity, such as explaining what they were about to do, checking the person was happy and willing to receive the support offered, and keeping the person covered as much as possible while helping them to wash. Three bedrooms were shared rooms. Staff had checked people were happy to share and were compatible. When one person needed privacy, a dignity screen was used to prevent the other person seeing them.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. One person told us, "I only have the ladies help me, not the men." This

information was included in people's care plans, known to staff and followed.
Staff were also aware of, and supported, people's cultural needs. For example, one person's religious believes meant they could not eat certain food and this was accommodated.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified relatives and people who were important to the person. People and family members confirmed that staff supported them to maintain their relationships; they were encouraged to visit at any time and to take the person out if they wished. A relative of a person who had died still visited the home, as did a person who had previously lived there. They each found comfort from this and were made welcome by staff.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, staff described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach or by gently reminding them when needed. Care plans also advised staff to promote independence. Typical comments included, "Enable [the person] to do as much as possible but provide support when needed." A staff member told us, "[One person] was being hoisted to the toilet [during a recent stay in hospital]; but we found with a little support they could walk and didn't need the hoist."

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. However, for some people we found this was not always the case.

The care needs of a person who had a catheter were not always managed appropriately. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters can be prone to becoming blocked if good fluid input and output is not maintained. Staff had been trained by a community nurse to flush the catheter when it showed signs of blocking. However, there was no care plan in place to inform staff how to monitor this or the action they needed to take to support the person with their catheter. Staff told us they were supposed to monitor and document the person's fluid output to help them identify when a blockage may have occurred, but records showed this was not done consistently. Failing to spot a blockage could put the person at risk of fluid retention or infection, which would require prompt medical intervention. We discussed this with the registered manager who agreed to address the way staff monitored the person's fluid input and output.

Three people had diabetes. Staff were aware that these people needed to receive a low-sugar diet and some information was available to help them identify the signs people would display if their blood sugar levels were too high or too low. However, this was not supported by cohesive care plans to ensure the needs of people with diabetes were met consistently. Staff took one person's blood sugar levels daily, but did not take action when the person's levels were outside their normal range, which had occurred on eight of the previous 12 days. The person's doctor told us that the results would not have necessitated urgent action, but that they would have wanted to know about one reading that was particularly high. They said, "There's no point testing unless you're going to act on the results." We discussed this with a senior member of staff, who agreed this was an area for improvement.

A range of activities were organised but these were not run consistently and there was no link between people's interests and the activities that were arranged. One person told us, "There's a different activity every day; we're always occupied. I like anything that's going on, like quizzes or entertainers." However, another person said, "There's not much going on at the moment, although [staff] do lay on outings." A social care practitioner told us they were concerned about the low level of activity provision at the home and the impact this could have on people.

Planned activities were not advertised within the home. Staff told us an entertainer visited every three months and an organisation brought in animals, such as rabbits and owls, once a month. In between, staff sometimes organised quizzes, sing-songs, arts and crafts for people. However, these were only run on an ad hoc basis as time allowed and records showed they were not organised regularly. On the day of our inspection, the activity arranged for people was watching a DVD. A staff member told us, "We haven't got the staff to organise activities or take people to [a day club] like we used to. [One person] is isolated in their room and we don't have time to do one-to-one activities with them." A senior staff member had spent time finding out about people's interests and which activities they wished to be organised. However, another senior staff member acknowledged that this was "still in its infancy" and the work had not been completed.

For example, the interests listed for the person isolated in their room were 'talking' and 'doing quizzes', but records showed these had not yet been arranged for them. Therefore, the provider was unable to confirm that people were receiving adequate mental stimulation, that met their needs, through the provision of meaningful activities.

The failure to ensure that people's care and treatment was appropriate and met their needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other cases, staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia, and their needs were met. Staff knew how each person preferred to receive care and support; for example, when people liked to get up and go to bed, and where people chose to spend their day. One person needed to be encouraged to mobilise after having had surgery and we saw staff doing this in a consistent way that would promote recovery. Care plans included key information about the person's normal daily routine, mobility, medicines and continence. They were reviewed regularly by care staff on a monthly basis to help ensure people's current needs were identified and met. Records of daily care provided confirmed that most people received care in accordance with their individual needs.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. One person told us, "We have our regular time to get up and then it's our own time. If I don't want to come down for breakfast, I have it in my room." Another person said, "I can choose what I do and when I go to bed." People were also able to bathe whenever they wished and were given the option of a shower or a bath. One person told us, "I like showers two or three times a week; it's more than enough for me." Care records showed that people's choices were respected and accommodated. A staff member told us, "This is their home; they can do what they please."

Staff provided examples of where they had responded appropriately when people's needs changed. A staff member noticed a lump on one person's breast while delivering personal care. The person was referred to a specialist, which resulted in a diagnosis of cancer, that was able to be treated. If the lump had not been spotted at such an early stage, the outcome for the person may not have been so positive. Another person experienced pain if they stayed in one position too long and staff took action to prevent this. A visiting care worker from another provider told us, "[The person] gets pain in her back, so [staff] let her spend some time in a chair, then some time in bed, which helps."

When people were admitted to hospital, staff completed a 'hospital transfer form' to provide information that would assist medical staff to understand the person's needs. In most cases, a staff member also accompanied the person to aid communication between the person and medical staff, particularly if they were living with dementia and struggled to express themselves verbally.

There were arrangements in place for people to provide feedback about the service. These included feedback forms that people or relatives could send to an external organisation who then posted the feedback on the provider's website. One person told us, "[The registered manager] checks to see if everything is OK or anything needs changing. I wouldn't change anything." Following feedback from a family member, action was taken to protect fire safety equipment that a person was observed to be tampering with.

People and family members felt senior staff were approachable and that any concerns or complaints would be listened to and addressed effectively. One person said, "I've never had to make a complaint, but if I had

to I would talk to the staff or the manager." The home had a complaints policy, but this was not advertised or made available to people. A senior staff member told us, "People used to get a welcome booklet that included [information about how to complain], but there's nothing in place for that now." They told us they would address this and make sure the information was available to people.

Inadequate

Is the service well-led?

Our findings

The provider is registered with CQC as a two-person partnership. The registered manager told us that one of the partners died in February 2013. Shortly before their death, the ownership of the business was transferred to the registered manager and the surviving partner jointly. However, none of the registered persons notified CQC of the change of ownership or partners, as required by the conditions of their registration. This meant we were not able to consider whether the new partnership and governance arrangements were suitable.

The failure to notify CQC in writing of the death of a partner was a breach of Regulation 21 of the Care Quality Commission (Registration) Regulations 2009.

Following our last inspection in August 2015 we published an inspection report detailing improvements that were required to the service. These included the need to improve arrangements for supervision and appraisal, and the need to follow the principles of the Mental Capacity Act 2005 (MCA). We issued a requirement notice in respect of a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We wrote to the provider requiring them to send us an action plan detailing how they would become compliant with the regulation. They did not send us an action plan as required. The provider did not act on the feedback provided in the report as staff were still not receiving supervision or appraisal and did not understand their responsibilities to protect people's rights under the MCA. The provider had not taken sufficient action to meet the requirements of the regulations. In addition, some aspects of the service that were previously rated "good", and compliant with Regulations, had since deteriorated. At this inspection, new breaches of Regulations were identified.

The provider had a quality assurance process in place, although this was not well-developed and did not always identify issues that needed improvement. A senior staff member told us, "Things need tightening up." For example, care plans were reviewed monthly by a care staff member and then updated by the deputy manager. There was a list of topics staff were expected to review, including "the client's routine, health and mobility", but this did not include the person's nutritional needs. The reviews had not identified that two people had experienced significant weight loss and this had not been addressed.

The medicines audit was limited to checking the quantity in stock and that all the medication administration records had been signed. However, it did not look at the broader medicines management arrangements to check they were operating effectively. It had not identified that some medicines were not being stored in accordance with enhanced security requirements or that the competence of staff to administer medicines was not reviewed regularly.

A spreadsheet was used to monitor staff training. Entries on the spreadsheet were overwritten with the words "In process" when a staff member had been asked to complete a workbook of refresher training. This meant the information about when the staff member's current training certificates expired was lost and the provider did not have ready access to accurate, up to date information about when staff last attended specific training. The system had not identified that staff training in some key subjects, such as medicines and supporting people to move, was out of date and needed refreshing to enable staff to meet people's

needs.

The provider had failed to act on feedback provided by relevant persons or to send a written report to CQC detailing how they would become compliant. They had failed to operate effective systems to assess, monitor and improve the quality and safety of the service provided. These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, we issued an overall rating of 'Requires improvement' to the service. Providers are required to display their ratings conspicuously on the premises and on their website. We saw the previous rating was displayed on the home's notice board for the information of people and visitors; however, it was not displayed on the provider's website. There was a link on the provider's website to the CQC website, where this information could be found, but the link was not on the homepage of the provider's website, so was not conspicuous.

The failure by the provider to display the previous CQC rating on their website was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a duty of candour policy in place to ensure staff acted in an open way when people were harmed. The registered manager followed this when a person fell on two occasions and sustained a serious injury. They notified the relevant family member of the incidents by telephone, which the family member confirmed when we spoke with them. However, the registered manager did not follow this up with a letter of apology, detailing the circumstances of the falls, as required by the regulations. We discussed this with the registered manager who said they had not been aware of the need to do this, but would ensure it was done in future.

The failure to act in an open and transparent way by providing information in writing to relevant persons was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families told us they were satisfied with the way the home was run. One person said of the service, "It's run very well." Another person told us, "It's fantastic the way it is organised." The registered manager visited the service two to three times a week and when not at the home was always available to staff for advice and guidance on the phone. The deputy manager told us their role was mainly administrative, together with some night shift cover. Therefore, people's day to day care was largely overseen by the two senior staff members.

Although people were satisfied with the way the home was run, staff told us they did not always work well as a team and felt their morale was low. They said the reasons for this included a dispute with the registered manager around their entitlement to annual leave; the lack of staff supervision or appraisal; and the absence of opportunities to have their voices heard, such as in staff meetings.

One staff member told us, "There needs to be more communication between people. There's quite a bit of tension; people don't feel listened to by management. We don't feel appreciated, other than by the residents." They added, "Morale has not been very good for the last month or two; it's been quite low. Staff are just frustrated as there isn't enough communication." Another staff member said, "We don't work well together. One person will tell you one thing, one will tell you another. For example [which forms we should complete when a person falls]. Some will tell you [to complete a form] and others say not to bother."

A senior staff member confirmed that there was friction within the staff team. They said, "We don't always

work well as a team. Morale is low with staff and you get a bit of back-stabbing." The deputy manager told us, "We have a small group [of staff] and they wind each other up. [Some staff] are really good, but they are demoralised by [other staff]." The registered manager told us they were sometimes frustrated by the attitude of staff and would avoid working with them on occasions.

Staff told us they tried not to let their differences affect the quality of the care they delivered to people. However, poor communication meant staff did not always share relevant information. For example, although a staff member had been monitoring people's weights, other staff did not realise that two people had lost weight and needed extra support. Also, although staff recognised the need to monitor a person's catheter output, information about this was not shared between staff in a coherent way. A staff member told us, "[A person] fell last week but it wasn't documented until Monday; I only heard about it third hand. I wasn't told about it properly at handover; so I didn't know about possible health changes or to offer pain relief [to the person]."

A team meeting was planned to meet with staff to discuss the culture and values of the service and to address staff concerns. A senior staff member told us, "We did have [staff meetings] previously, but they went a bit wrong as the format didn't work; so, we're trying a fresh approach and want it more to be about listening to [staff] and their ideas."

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	Regulation 21 Registration Regulations 2009 Death of service provider The provider had failed to notify CQC of the death of one of the registered partners. Regulation 21(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that care and treatment provided to people was appropriate and met their needs. Regulation 9(1) and 9(3)(a)b) & (I).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed safely. They had failed to ensure that risks of people becoming malnourished were managed effectively. Regulation 12(1), 12(2)a), (b) & (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to ensure that they acted in an open and transparent way by providing written notifications of notifiable safety incidents to relevant persons. Regulation 20(1) and 20(4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to conspicuously display their CQC performance rating on their website. Regulation 20A(1) and 20A(2)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties. Regulation 18(2)(a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and support were only provided to people with the consent of the relevant person. Regulation 11(1)(2)&(3).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems or processes to ensure compliance with the Regulated Activities Regulations 2014. They had failed to assess, monitor and improve the quality and safety of the service provided; they had failed to assess, monitor and mitigate the risks to the health, safety and welfare of people; they had failed to act on feedback included in the previous CQC report. (Regulation 17(1) and 17(2)(a), (b), (e) & (f).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements.