Hawkfish Ltd

Queen Margaret's Care

Inspection report

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Ratings

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

Overall summary

Queen Margaret's Care is a service which provides personal and nursing care for up to 44 older people with nursing care needs. There is a passenger lift to assist people to the upper floors and the service is located close to local shops with an accessible area to the front and side of the property. On the days of inspection there were 40 people living at the home. A suspension on admissions from the local authority had been recently put in place due to concerns about the quality and safety of care at the service and had yet to be reviewed. The service was accepting privately funded admissions.

The home had two registered managers 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.

At the last comprehensive inspection on 24 February 2015 we found that the registered provider had not protected people against the risk of insufficient assessment of their mental capacity This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

At this inspection on 13 and 17 November 2015 people had comprehensive mental capacity assessments in place and were protected with regard to their mental capacity.

At this inspection the registered provider was not providing sufficient suitably deployed, experienced staff to safely meet the needs of the people who lived at the home. **This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At this inspection the registered provider failed to ensure that the risks to people around their clinical care needs were minimised. This was because clinical care charts were not consistently completed in line with people's care plans. **This is a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At this inspection the registered provider failed to ensure the provision of care and treatment in a safe way for service users. **This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Although some staff were observed treating people kindly. Staff did not always treat people kindly or with respect. We made a recommendation about this.

The premises were clean and hygienic. Laundry was well managed to comply with infection control best practice. Staff followed infection control best practice guidelines to protect people from the risk of cross infection. This meant that people were protected from the risk of cross infection. We made a recommendation about the use of colour coded sharps bins to ensure these were disposed of safely.

Records in relation to people's life histories, goals, Interests and preferences were not always sufficiently detailed or informative to support staff to offer responsive care. We have made a recommendation about this.

Care plans had improved to include a narrative of people's care needs in relation to clinical and social care needs. However, improvements were still required to ensure staff understood the pathway of care for each person. Care plans, risk assessments and charts did not always give clear consistent guidance about each person's care.

People told us that they were satisfied with the care at the service. However, we found that those people who were most vulnerable and not always in a position to speak with us were most often those who did not have their needs fully met.

The premises were well maintained and safe.

Medicines were handled safely to protect people, though some improvements were required to the policy and procedures and to the recording of topical medicines such as creams.

Staff were trained and supervised to support them to meet people's needs.

A range of activities was on offer which had been drawn up in consultation with people at the service. People told us they enjoyed these.

The service handled concerns and complaints according to their policy and procedures, to ensure people were listened to and any concerns acted upon. People told us that they were confident to raise any concerns with the registered managers or registered provider.

Staff did not always follow the lead of the registered manager to ensure the service was well led. The registered provider and registered managers along with clinical care staff did not always communicate in a way which promoted a consistent view of the vision and values of the service.

There was a range of quality audits in place which supported the registered managers and staff to improve practice. The registered manager had been responsive to recent concerns raised over the quality of care at the service and had devised detailed checks of staffing performance in key areas to support the service to improve.

People were consulted for their views and these were acted upon wherever possible.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety were assessed and sometimes acted on and risk plans were in place. The registered provider could not be assured people were sufficiently protected or that people received safe care.

Staff were not always safely recruited to protect people.

There were not always sufficient staff, who had the skills and experience to offer appropriate care and they were not always well deployed within the home to ensure people received safe care.

People were protected from the risks of acquiring infection because the home was clean and hygienic.

Medicines were safely handled.

Is the service effective?

Requires improvement

The service was sometimes effective.

People did not always have their health care needs met, including their needs in relation to nutrition, hydration and pressure care.

Staff were supported in their role through supervision and appraisal.

Staff received induction and appropriate training to protect people's needs.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Requires improvement

The service was sometimes caring.

People told us that staff were kind and caring.

We observed that some staff were kind and compassionate and some staff knew people well. However, some staff did not give people time and were abrupt with them.

Is the service responsive?

Requires improvement

The service was sometimes responsive to people's needs.

Care documentation for the most vulnerable people living at the home did not always record important changes to their care needs consistently.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests to ensure they had the information they needed to offer person centred care.

Summary of findings

Activities and outings were available and had been planned with people's preferences in mind. People said they enjoyed taking part in these.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The service had two registered managers in post. There was ineffective communication between the registered provider, the registered managers and the clinical lead and people did not benefit from a management approach which embodied the same vision and values.

People told us that they enjoyed living at the home and that they liked the registered provider and the registered managers. They told us that the registered managers explained things to them and consulted with them about their care.

Staff were supported in staff meetings where they could discuss and share views on the quality of care.

People benefitted from a range of quality audits and monitoring of the service. However, care records were not always consistent or robust enough to provide people with quality care.

Queen Margaret's Care

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 17 November 2015 and was carried out by one adult social care inspector and a specialist nurse advisor. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the public through our 'share you experience' web form, the local authority safeguarding team and the hospice at home team which operates from St Catherine's Hospice in Scarborough to provide outreach support. We also considered information shared with us by the police. Before the inspection we would usually ask 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. On this occasion, this was an inspection to provide a new rating as well as following up on concerns raised by the local authority and the police and we did not request the PIR. However we gathered the information we required during the inspection visit.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people who lived at the home and seven members of staff including the registered managers. We also spoke with two health care professionals and three health and social care professionals before the inspection visit.

We looked at all areas of the home, including people's bedrooms with their permission where this was possible. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. We also looked at records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at Queen Margaret's Care.

Inadequate

Is the service safe?

Our findings

Staff told us that inexperienced staff were on rota with skilled and experienced staff who could support them. There were 40 people living at the home when we visited. We found that during the morning shift there were usually eight care workers on rota, which included a team leader. Additionally there was always a registered manager on duty and one nurse. The clinical lead was planning to spend some time as supernumerary in order to fulfil their lead role, however this did not regularly happen, and they often worked shifts on the floor as the only nurse on duty. In the afternoons, five care workers were on duty with a nurse and a registered manager. Between the morning and afternoon shifts there was an overlap when there were often nine care workers on duty. Domestic and kitchen staff were additional.

When we spoke with staff they gave differing accounts of how adequate they felt the staffing levels were. Some staff felt that they had sufficient time to care for people safely, though all told us that they had little time for chatting or spending time on anything other than care tasks. Other staff felt that staffing ratios were a more serious problem. One member of staff told us that the ratios on the rota were often not the actual ratios because of staff leaving at short notice and sickness. They told us the home sometimes operated with six or seven care staff with one nurse each morning to care for forty people, and four or five care staff with one nurse in the afternoons which they felt was insufficient to offer safe care. Although this was not recorded on the rota, staff told us this was what regularly happened. “We can cope with the personal care tasks we need to carry out with the full staffing complement. However, if a member of staff does not turn up for work or is off sick, then we all suffer and the people living here get a rushed service where there is the potential for a mistake.”

We asked nursing staff why they thought that there were gaps in charts and other care records. They told us “We don’t always have time to complete them, and we forget. As soon as we finish the care for one person we need to go straight to the next one.” We received an anonymous concern during October 2015 that staff were taking a long time to answer call bells and that they had observed one person having to wait almost an hour before they were supported to use the toilet. The anonymous alerter wrote that this had made the person visibly distressed. We spoke with one person who lived at the home who told us, “The staff do a great job but one or two of them just don’t seem to turn up for work sometimes. When that happens it is awful for the staff who are left, really struggling to do everything they need to do.”

Our observations gave a mixed view of how busy staff were. On the first day of inspection we observed staff in the morning in the main lounge area of the home rushing to attend to call bells. There was a chaotic and stressful atmosphere with staff appearing to lack a coordinated response.On this day there were seven care workers on duty with the clinical lead as the only nurse on duty. At lunch time staff were more relaxed and we observed that they took time to speak with people and to offer care in a well-paced manner. On the second day, when there were eight staff on duty in the morning, there were times when they were very rushed, however, when we spent time on one of the upper floors of the home, we noted that call bells were attended to within five to ten minutes and that staff were always polite with people when they entered their rooms. These differing observations showed that the quality of care people received was not consistent.

People told us that they felt safe. Although some people told us they sometimes needed to wait for longer than was comfortable for them before they were attended. One person told us, “I feel sure that when I call then staff will come as soon as they can. If they take a while they always apologise and explain that they were delayed.” Another person told us that they felt secure because of the call alarm which they wore around their neck. “I am never out of reach of the call bell because it is here all the time wherever I am sitting.” One person told us that they felt safe with sufficient staff when they went out on a trip to the sea life centre recently.

However, the registered managers told us that they had used a staffing ratio tool which reflected current guidance to calculate the number of staff who should be on duty to care for the number people with the dependency levels of those who lived at the home. This had revealed that there should be two nurses on duty each shift for the number and dependency levels of people who lived there rather than one. We noted that throughout our inspection care staff were regularly asking advice from the clinical lead which made it difficult for them to attend to their own nursing tasks. They told us that as they had a large number of recording tasks to complete, the lack of protected time

Inadequate

Is the service safe?

off the floor to complete these made it difficult to ensure people had a safe service. Our observations on the days of inspection confirmed there was a risk that people would not receive a safe service. The registered manager told us that they were finding it difficult to recruit to the nursing posts they had vacant. However a plan was in place to remedy this with an initiative to encourage oversees nurses to take up employment in the home.

Overall this meant that at the time of inspection the home was not providing sufficient deployed, experienced staff to safely meet the needs of the people who lived at the home. **This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had an open and positive approach towards managing risk. For example, one member of staff told us, "We have been taking people on trips out and have assessed the risks around doing this."

Updated files had an overall risk assessment for each person regarding their health, welfare and the environment completed within seven days of admission. Some files had been updated to include a narrative risk assessment which was person centred and which also focused upon how to maximise freedom.

Staff told us that the person's behaviour which others might find challenging was managed with a positive attitude. One member of staff told us, "If a person's behaviour becomes a risk to other people nearby we encourage the person to leave the area and we talk with them to find out what is troubling them. Often people are feeling upset and need to know we are there to listen."

However, we heard from a mental health care professional who felt that the service had admitted a person whose needs could not be met by the service, due to the challenging nature of this person's needs around their mental health. Some staff expressed concern that this person had been admitted as within a short time following admission there were clear risks to the person and other people who lived at the home. A registered manager told us that information about mental health issues had not been forthcoming during the assessment process, however, health care professionals we spoke with told us that the person's medical and behavioural history was well known to them. The assessment process had not been sufficiently robust to protect people from the risk of harm.

Some older formatted care files did not have comprehensive risk assessments for all relevant areas of care and some included tick box risk assessments, which did not give full guidance for staff to best manage individual risks.

As a result of some issues which had arisen about safe care within the home, the manager had set up daily spot checks on staff practice. Checks had revealed that a member of staff had not followed the written instructions on managing risk safely and was about to transfer two people on two separate occasions who required a hoist without using the hoist as set out in the care plan. The spot checks had prevented unsafe practice before it occurred, and the member of staff had been transferred to other duties until they had been safely retrained. However, despite remedial action by the registered managers we found evidence that the service had not ensured that care and treatment was provided in a safe way. Some risk assessments were confusing when read alongside care plans, which sometimes contradicted them and led to them being inconsistently implemented. For example, for one person a risk assessment was in place for supporting them to receive adequate nutrition via a Percutaneous Endoscopic Gastroscopy (PEG) but there was no risk assessment around positioning which would have been expected due to the person's vulnerability in this area. Staff could not always tell us that people were cared for in a way which minimised risk.

Overall there were not always clear and understandable links between risk assessments, care plans and monitoring charts to ensure staff had a clear understanding of how these were coordinated to give a consistent approach and provide safe care. We found evidence that people had not always been protected from harm or the risk of harm. **This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The home had a policy and procedure on staff discipline and the registered manager explained how they had used this in the last year to ensure people received safe and appropriate care.

Inadequate

Is the service safe?

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines, however as it was not dated it was not possible to see when it had been reviewed. The policy did not state whether it was drawn up in accordance with current regulations and guidance based on the recognised National Institute for Health and Clinical Excellence (NICE) guidelines on managing medicines in care homes or the Royal Pharmaceutical Society 'The Handling of Medicines in Social Care'. This meant there was a risk that people may not have their medicines managed according to these guidelines. On the second day of inspection the clinical lead had added the NICE in brief guidelines to the medicines policy.

We observed part of a medicines round and noted that a nurse dispensed medicines by tipping them into their hand, before passing them to the person. This posed an infection risk and was not in line with the home's own procedure.

We saw some handwritten entries on MAR charts. There was a record of who had authorised changes. However, some MAR sheets with hand written instructions were not signed by two members of trained staff, as NICE guidelines advise. This meant there was the risk that people may not receive their medicine as prescribed.

We saw evidence of topical medicines being prescribed; however instructions for use were often "apply as directed". There were not always associated body maps as they should be which meant that the registered managers could not be assured that topical medicines were administered as prescribed for people's benefit.

Staff showed us how unwanted or out of date medicines were disposed of and records confirmed this. However, recording for this was inconsistent with sometimes one or no signature for medicine disposal.

Despite these shortfalls people were protected by the other ways in which the home handled medicines. Only qualified nurses administered and handled medicines within the home. The home used a Monitored Dosage System (MDS) with medicines supplied on a 28 day cycle. (A MDS is where medicines are pre-packaged for each person). All cupboards that contained medications were kept secure with coded locks. We saw that medicines were recorded on receipt, administration and disposal.

We saw that written guidance was kept with the medicines administration records (MAR) charts, for the use of "when required" (PRN) medicines. This meant that there was written guidance for the use of PRN medicines and staff were provided with a consistent approach to the administration of this type of medicine.

Appropriate arrangements were in place for the administration and storage of controlled drugs, which are medicines which may be at risk of misuse. We saw the balance remaining was checked against the amount in the pack or bottle on each administration and we saw evidence of a weekly check of stock balances, to ensure that the balance documented tallied with the actual quantity of controlled drugs available.

Systems were in place to ensure that the medicines had been ordered and we saw that for two people, medicines had been arranged in anticipation of future needs and were available in the home.

The registered manager told us that people's medicines were regularly reviewed. This was to ensure medicines were suitable and safe for current needs. Records of care planning reviews confirmed this. Staff were knowledgeable about individual's needs around medicines and any associated risks. For example they told us about pain relief medicines and how these were managed to make sure people received effective pain relief whenever needed.

We saw that the home regularly reviewed environmental risks and carried out regular safety audits. At the last inspection we found that overflow sharps were disposed of using a pencil case which caused the risk of sharps injury. There was no separate hand washbasin in the treatment room and there were a number of free standing soap containers, which posed an infection control risk. We also found that some wheelchairs and seat covers were dirty. We made a recommendation about this.

At this inspection, in the treatment room we found an inappropriate purple lid sharps bin. However, a staff member told us that the waste contractor would still dispose of these sharps bins in the same way as the yellow lid sharps bins (for the disposal of sharps contaminated with medicines).

We recommend that the registered provider consults best practice guidance on the correct use of colour coded sharps bins.

Inadequate

Is the service safe?

At this inspection the home was clean. Some carpets were worn, thin, and placed over uneven surfaces which made effective cleaning difficult. Some carpets were taped with the edges of tape coming away which caused an infection control hazard. However, domestic staff told us they worked to cleaning schedules and there were sufficient domestic staff to ensure the risk of cross infection was minimised. We saw a separate hand wash basin in the treatment room and wall mounted liquid soap and paper towels which are recommended for effective infection control.

We asked about individual fire evacuation plans (PEEPs) for people living at the home. The registered manager told us that the home had a sprinkler system and a plan in place where people would be moved to the nearest safe zone and not evacuated from the building in the event of fire.

We checked recruitment practices within the home. Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received on three staff files we looked at. On one staff file there was only one written reference , however, the registered manager told us that they had followed this up with a phone call to the referee and they had been satisfied with the response. However this was not recorded.

We saw records of training in infection control which were all up to date. Clear timescales were recorded for when this needed to be updated. We asked two members of staff about infection control and they understood what good infection control practice was to ensure people were protected. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people.

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. When we spoke with staff about this they were able to describe different types of abuse and what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. This gave us evidence that staff had the knowledge to protect people appropriately.

The registered managers told us that they had taken part in local authority safeguarding investigations and that they had provided information so that these investigations could be carried out effectively. There were four ongoing safeguarding investigations by the local authority at the time of the inspection. None of these were resolved and needed further investigation. The alerts had been raised in relation to eating and drinking, untimely access to health care support, and acts of omission which allegedly led to a person's discomfort. The registered managers had carried out action in relation to the safeguarding investigation and had followed the staff disciplinary policy and procedure in the case of one investigation to ensure people were protected from harm. This included registered managers acting to suspend staff from duty where this was appropriate and necessary.

Requires improvement

Is the service effective?

Our findings

People told us that staff attended to their clinical care needs well. One person told us, "I have no complaints, they are really good and do those things for me I can't do for myself." Another person told us, "They always ask me how they can help and wait for me to tell them how they can help in the best way."

The service had begun to use a new care plan format which allowed for a narrative description of people's individual care needs in relation to eating, drinking, pressure care and other clinical care needs. Plans at this inspection included information for staff on such areas as eating and drinking, maintaining healthy skin condition and safe moving and handling. The older 'tick box' care plans did not give as detailed guidance as the newer ones.

The older 'tick box' care plans did not give staff specific information about how the person's care needs were to be met and did not give instructions for frequency of interventions and what staff needed to do to deliver clinical care in the way the person wanted. We saw that the risk of choking had been highlighted on some 'tick box' care plans but there were no clear guidelines on what staff needed to do to ensure the risk was minimised. When we spoke with staff, they were able to tell us what needed to be done to ensure people were protected around the risk of choking, however, there was a risk that people would not receive the care they needed.

Care plan folders contained multiple care plans many of which were out of date and were therefore confusing. Folders were a mixture of old care plans and up to date ones which were not always in a chronological correct order. This meant there was a risk that staff would follow out of date guidance.

Three of the ongoing safeguarding investigations were around clinical care or timely access to health care support. Though these investigations were not concluded, there was evidence at this stage that people had not always had their care needs met in these areas. **We recommend that the registered provider consults best practice guidance to ensure people are consistently protected with regard to their clinical care needs.**

Although the older care plans were not comprehensive the updated care plans included comprehensive risk assessments which followed best practice guidelines. These plans gave instructions for frequency of interventions and what staff needed to do to deliver clinical care in the way the person wanted.

Updated eating and drinking plans included records of weight monitoring where necessary and advice from specialists, for example around modified diets such as high calorie or textured diets. In some care plans there was reference to charts which were required to monitor people's eating and drinking or their access to nutrition and fluid in other ways, for example through a Percutaneous Endoscopic Gastroscopy (PEG) which is a way of introducing food, fluids and medicines directly into the stomach. Some of these charts were correctly completed to ensure people had the care they needed.

During lunch time we observed that people who had chosen to sit in the dining room were assisted to their tables well in advance of the meal. (In the case of four people we observed they were brought into the dining room at around 12 noon and lunch was served at 13.30). However, although this meant people had a long wait, staff during this time were relaxed and chatted with people. Those who required support from staff were given this in a well-paced way. The meal looked appetising and people had chosen different meals and drinks according to their preferences. At other times of day people were regularly offered drinks and snacks and people had drinks of water and juice close to them at all times, both in the communal areas of the home and in their individual rooms.

Care professionals had been consulted and their advice was included in care plans. For example the tissue viability nurse, the community mental health team, the dietician and the Speech and Language Therapy Team (SALT). We noted the views of a member of the community mental health team who did not feel the home always managed people's mental health needs well and that they had recently admitted a person whose needs they struggled to meet, and who needed to be moved to another more appropriate setting. We spoke with a health care professional who told us that GP requests often appeared to be decided upon by the provider rather than the nurse in charge. This had sometimes led in their opinion to inappropriate requests for a medical professional to attend. They told us that the nurses contacted them appropriately and followed their advice. They said that the

Is the service effective?

nurses were skilled at managing people's pressure care to ensure that any vulnerable areas were treated to minimise the risks involved. They had often witnessed staff moving people appropriately for their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this comprehensive inspection improvements in the way the service assessed mental capacity had been made. 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. Staff told us that they had received training in the MCA and DoLS and could correctly tell us the main principles. The registered manager told us that a number of staff had received this training and that all staff had received training in the five main principles of the MCA and DoLS. This meant staff had the information they needed about the MCA to ensure people were cared for according to its principles.

The MCA, DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The manager had made a number of DoLS applications to the local authority, (The 'Supervisory Body') and at the time of the inspection two of those people had been assessed and the DoLS authorised. Care planning was in place to ensure that the provider was complying with the conditions applied to the authorisations.

People's consent to care and treatment was recorded in their initial review. Where appropriate Do Not Attempt Resuscitation consent forms were correctly completed with the relevant signatures. The support people required to maximise their independence in decision making was recorded, including the support of informal advocates and Independent Mental Capacity Advocates (IMCAs). This ensured people were cared for in line with the principles of the MCA.

We saw that care plans took account of when a Best Interests decision was needed. They recorded that Best Interests decisions had to be carried out by a multidisciplinary team in line with the MCA.

Staff understood the MCA and gave a good account of the five main principles of MCA, DoLs and Best Interests decision making.

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they told us they developed an understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of people they supported and knew how their needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

Staff had received the full range of mandatory training. Updates were planned to ensure staff knowledge was refreshed and in line with best practice. Staff had also received training in areas of care that were specific to the needs of people at the home. This meant staff were trained to offer people the care they needed.

Staff told us they were receiving supervision and support in their role. Records confirmed that staff had received regular supervision meetings since the last inspection with notes on areas for development and evidence of discussions about support needs. Appraisals were also completed, where staff were encouraged to review their performance over the year and to commit to develop their practice to improve people's quality of care. This meant that staff were receiving support and guidance to ensure people received effective care.

Requires improvement

Is the service caring?

Our findings

People told us that the provider, the registered managers and care staff were kind to them. One person told us that staff were sometimes too rushed, however, another person said that "Staff can't do enough. They are all really kind and lovely, I couldn't do without them." A health care professional told us, "The staff really do care about people, they work hard to make sure people get the care they need."

However, some interactions we heard from staff were not respectful or kind. For example one member of staff stated to a person, "I need the toilet as well, but I'll have to wait". A professional contacted us in September 2015 to raise a concern that they had observed a person ring their call bell, and asked to be taken to the toilet. The care worker told them they would have to wait as she was going off shift. This meant that the person was not treated kindly.

We recommend that the registered provider consults best practice guidance to ensure staff treat people with kindness and regard to their dignity at all times.

We spent some time with people in communal areas and observed that at times the staff were rushed and did not often engage with people. However, at other times they were more relaxed. We observed two members of staff talking in a kind and considerate way to a person who was upset, and staff spoke kindly to a person as they supported them to move using a hoist. During a meal staff sat at eye level with people who needed assistance and focused their attention on supporting them to eat their meal.

During our inspection visit, we observed staff taking time and care when they carried out care tasks and activities. We observed that staff visited people who spent most of their time in their bedrooms to ensure that they were comfortable, to offer drinks or snacks or carry out personal care activities.

One member of staff told us. "We don't have as much time as we would like to chat with people and to spend time with them to find out how they are feeling." Staff spoke to us with respect and affection for the people they were supporting. Another member of staff told us, "I treat everyone who lives here as though they were my own family. They all need kindness and care." Staff spoke about the need to respect each person's dignity and privacy, and that this included making sure bathrooms and toilet doors were always closed when giving personal care and covering people to protect dignity.

The staff and people we spoke with told us that the home encouraged visitors and we observed that a number of visitors were greeted by staff in a friendly way. Visitors told us that the staff always offered them refreshment and that they were made to feel welcome.

Those people who needed this were supported to access advocacy and people who lived at the home had used the service of Independent Mental Capacity Advocates (IMCAs) when they needed support in this area of their care.

Requires improvement

Is the service responsive?

Our findings

People told us that the staff understood them, their lives and interests and knew who and what was important to them. One person told us, "They know all about me, and they often pop in to have a chat about things I am interested in." Another person told us, "There is entertainment on every day." Another person said, "I have been out to the sea life centre recently, it was a great day and I really enjoyed it."

The older more 'tick box' care plans did not always contain information about people's social cultural or recreational needs. However, updated care plans contained these details. Information about people's personal histories, their likes, dislikes, important relationships and interests had been recorded.

Initial reviews were carried out with the person and any significant people involved and their views were recorded. Care plans were regularly reviewed to take account of changes to care needs, though sometimes up to date needs were not recorded throughout the care plan. For example, one review recognised that a person needed to be nursed in bed and that a hoist was no longer safe for moving and handling. The moving and handling risk assessment did not reflect this and was written as though the hoist was still in use. However, when we spoke with staff they told us that they knew the person was moved using a slide sheet and that the hoist was no longer used.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs. The frequency of daily notes however seemed vary from day to day so that it was not always possible to evidence that there was continuity of care.

Staff could tell us about people's care needs and how these had changed and they understood this despite care plans not always having up to date information. There was a risk however that all staff would not have the information they needed to give people the care they needed as their needs changed.

Updated files had personal histories in place. All had details of next of kin, and significant other people in each person's life. Life history documentation sometimes recorded people's medical rather than personal history with little mention of interests, hobbies, spiritual or cultural needs. Staff told us it was sometimes difficult to gain this information when people were discharged to them from hospital and that they built up a knowledge of each person gradually over time.

We recommend that the registered provider consults best practice guidance on maintaining accurate records to support staff to give personalised care.

Despite the shortfalls noted above, the home provided a range of activities and one to one pastimes which usually took place each afternoon when staff were not so busy with personal care tasks. The service employed an activities organiser who consulted with people about what they liked to do with their time. People and staff told us they were involved in trips out to places of interest, craft work, painting, hand and eye coordination games such as throw and catch, singing, looking through photographs and memory and quiz games. Staff told us that when the weather was warmer they would support people out to the local garden centre or for a short walk to the South Cliff.

Although they were rushed, we observed that staff visited people in their rooms and one person told us they felt staff never forgot about them. One person who spent most of their time in their room told us that staff popped in to talk with them often in the afternoon when they were less busy. We saw that staff often attended a person who shouted out for assistance. Everyone had a pendant call alarm, which meant that they could summon assistance wherever they were in the home. People told us they were encouraged to use their call alarms and we observed that people did use these, for example to ask for a drink or for staff to bring them a newspaper.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. The service had a complaints procedure and the registered manager told us they followed this to ensure people's complaints were appropriately dealt with. We saw two records of complaints which had been responded to appropriately and within the timescale set out in the policy and procedure. We spoke with a person who had raised a concern, and they told us that it had been quickly addressed and that they were now happy with their care.

Daily notes contained evidence of contact with optician, dentist and hearing professionals along with evidence of prescriptions for people regarding new spectacles, hearing

Requires improvement

Is the service responsive?

aids and dentures, so that people were supported with their communication needs. We saw an example of how the service used a 'faces' pain scale for staff to interpret level of pain for one person. Evidence was available in daily notes that this was being used by staff so that they could address the person's need in relation to pain management.

Requires improvement

Is the service well-led?

Our findings

In some clinical care plans there was no clear reference to charts when this would be expected due to the person's vulnerability in this area, for example, for repositioning, food and fluids. In all the care plans we examined where charts were in use, these were inconsistently completed with unexplained gaps and staff signatures missing. Records did not provide a clear pathway of care, with risk assessments, care plans and charts not always working together to give staff clear unambiguous guidance on how to offer the most appropriate care.

The registered provider failed to ensure that the risks to people around their clinical care needs were minimised. This was because clinical care charts were not consistently completed in line with people's care plans. **This is a shortfall in good governance and is a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People gave mixed views about the way the home was managed. One person told us that they "really liked the managers," and that they took time to come and see them and chat with them. Another person told us that because the two registered managers shared the role, there was a manager in the home for most of the week. One person who lived at the home told us "I think the staff sometimes take the Micky. They don't always listen to what they should do."

The registered managers carried out a range of audits and completed all care planning records and reviews. Audits were in place for example for medicines, infection control, care planning, health and safety and room audits. Spot checks had been put in place following recent concerns about whether all staff were carrying out care in line with their training and the care plan. Spot checks had picked up a number of errors and potential poor practice which had been addressed at the time. Medicines audits did not outline clear actions in relation to the findings; however, the clinical lead told us that they had implemented a number of improvements following these audits.

They told us that plans to improve practice were drawn up using the results of audits and shared with staff during meetings and supervision sessions. The written evidence to support this was not clear.

The service carried out surveys of people's views on the quality of service they received. This included such areas as personal care, involvement in care planning, whether people felt safe and secure, their views on social activities, and whether they knew how to make a complaint. We saw views expressed such as "Good all round care "and "I don't want to see anything changed."

At the last inspection the service did not have a clinical lead in place. Since then a clinical lead had been employed and the quality of clinical support to nurses and care staff had improved. Care staff had a named person to approach for support, and the monitoring duties around medicines were completed consistently by one person who held this overall responsibility.

However, the communication channels between the registered provider, manager; clinical lead and staff appeared to be ineffective. The clinical lead was not afforded the time to carry out their role effectively because rotas were not arranged so that they could spend time on their lead role. The registered provider appeared to manage the way in which care was delivered by the registered manager and clinical lead so that they were not free to exercise their professional judgement in crucial areas of service provision. For example, the registered provider required an e mail handover report for each shift which would result in frequent reworking of decisions which had been made by the registered managers and clinical lead. This lead to frustration and time consuming changes. A health care professional told us that the decision to call out a GP was often made by the registered provider following a handover report, and this would sometimes be different from the decision made by the clinical lead, who in their opinion, had a clearer and more up to date understanding of people's care needs. They told us this had resulted in some unnecessary health care professional visits to the home.

During recent professional meetings with CQC and the local authority the registered provider rarely agreed on the need for improvement and took a stance which was at odds with CQC, the local authority and other professionals. Their comments gave evidence that they had not kept up to date with best practice and were unclear about some of challenges that faced the service in relation to providing quality care. Following the last report, the provider wrote to CQC telling us they did not intend to address our requirement notice or recommendations as they did not

Requires improvement

Is the service well-led?

agree they were necessary. They also did not agree that recording should be improved, citing that an increase in the requirement for written records took staff away from their caring role and had a detrimental effect on care. However, the registered managers accepted that improvements were needed and acted on the requirement notice and recommendations from our previous report. This shows that the registered provider and the management team did not always share the same vision or values. This led to a degree of confusion and lack of clarity about the leadership and culture of the service.

Despite this the registered managers, care staff and people who lived at the home told us that the registered provider was passionate about good care, that they were supportive of them if there were difficulties. They told us that they visited the home often and spent time talking with people kindly and gathering their views. Staff knew that the home had a suspension of admissions in place from the local authority and they told us they had felt supported by the registered managers during the investigation of concerns which had been raised about the safety and quality of care.

People and staff told us that the registered managers were visible around the home and people told us that they were approachable and helpful when consulted. Staff told us that the registered manager was always available for advice and support at any time they were free. We observed that staff approached the registered managers and the clinical lead throughout the day of inspection in this way.

The manager consulted with people on a one to one basis regularly and during reviews, and recorded any areas where people felt improvements could be made. These were discussed in staff meetings so that the overall quality of care could be improved.

The manager and staff spoke about looking for ways to improve the quality of life for the people who lived at the home. For example, they spoke about developing the range of activities on offer to reflect people's interests. Some staff told us they felt valued and that their opinions were respected, other staff felt that they were insufficiently supported, that leadership was not always strong and that communication was not always clear.

The manager spoke of how staff had taken on board the need for change and recognised that a barrier to this was the difficulty in recruiting sufficient suitable staff, in particular nursing staff. The registered provider had begun to address this difficulty through an initiative involving supporting nurses to move into the area.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager.

The registered managers told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. They had carried out some joint working with another care provider to improve the quality of care planning and other records.

Notifications had been sent to the Care Quality Commission by the service as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that risk was sufficiently mitigated to care for people safely.**

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 **Records relating to the care and treatment of each person using the service were not always well kept or fit for purpose.**

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 numbers of well deployed, suitably qualified, competent, skilled and experienced persons to care for people safely.**