

New Century Care (Hastings) Limited

St Pauls Care Home

Inspection report

St Pauls Care Home
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Date of inspection visit: 22 and 26 May 2015
Date of publication: 10/07/2015

Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Inadequate



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

We inspected St Pauls Care Home on the 22 and 26 May 2015.

St Paul's Care Home provides accommodation, personal and nursing care for up to 25 older people, some of whom have limited mobility, are physically very frail with health problems such as heart disease, diabetes and strokes. There were people at St Paul's also living with dementia and receiving end of life care. There were 20 people living at the home at the time of our inspection. Accommodation is arranged over three floors and each

person had their own bedroom. Access to the each floor is gained by a lift, making all areas of the home accessible to people. St Paul's Care Home is a large detached house in a residential area of St Leonards on Sea, close to public transport, local amenities and some shops. The service is owned by New Century Care Limited and is one of six homes in the South East.

We last inspected the home 25 July 2013 and no concerns were identified.

Summary of findings

People commented very positively about the care and support received and their experience at St Paul's Care Home. However, the inspection highlighted significant shortfalls that had the potential to compromise the safety of people in the service.

A manager was not in post following the resignation of the registered manager in March 2015. The organisation have placed a relief manager from the organisation in place until they have recruited to the post. 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 and associated regulations about how the service is run.

People's safety was being compromised in a number of areas. Whilst people's medicines were stored safely and in line with legal regulations, we found shortfalls in recording, poor administration and medicines for some people were out of stock for seven days. We also found poor recording of skin creams, dietary supplements and 'as required' medication.

Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as wound care did not have sufficient guidance in place for staff to deliver safe care. Guidance for staff to follow to deliver end of life care with specific directives from the GP and hospital were not recorded and therefore we were not assured that their needs were being met. Not everyone had risk assessments that guided staff to promote people's comfort, skin integrity and the prevention of pressure damage. This had resulted in potential risks to their safety and well-being. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Where people's health had changed considerably, care plans did not reflect the changes and therefore staff were uninformed of important changes to care delivery. Information was not always readily available on people's life history and there was no evidence that people were involved in their care plan. The lack of meaningful activities for people at this time impacted negatively on people's well-being.

Whilst people were complimentary about the food at St Paul's Care Home, the dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink in a dignified manner. The meal delivery was not efficient and people told us they often did not get a hot meal at lunchtime.

Whilst some quality assurance systems were in place, we found other organisational quality assurance systems had not been completed, such as wound care and accidents and incidents. The quality assurance systems had not identified the shortfalls we found in the care delivery

Arrangements for the supervision and appraisal of staff were not effective. Although staff told us that meetings took place about concerns, regular supervision and appraisals, intended to monitor the training, on-going development and the competence of staff, had lapsed.

Whilst the overall maintenance of the home was adequate, only one communal shower was working and no bath was available for use if people wished a bath.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated they had built rapports with people and people responded to staff with smiles. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

Summary of findings

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed by St Paul's Care Home all had registration with the nursing midwifery council (NMC) which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

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?

St Pauls Care Home was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone and therefore placed people at risk.

People were placed at risk from equipment which was not suitable for their needs and poor moving and handling techniques.

There were not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

Medicines were stored safely. However poor recording and unsafe administration of medicines placed people at risk of not receiving their prescribed medicines. Recording of skin creams, sub-cutaneous fluids, dietary supplements and as required medication was inconsistent.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Inadequate



Is the service effective?

St Pauls Care Home was not effective. Meal times were a solitary and inefficient service with food being served to people who were in an inappropriate position to eat. We also saw that staff did not always follow good practice guidelines while assisting people to eat. There was no dining experience offered. Senior staff had no oversight of what people ate and drank as not all records were accurate or completed correctly.

Not all staff received ongoing professional development through regular supervisions, and essential training that was specific to the needs of people had not been undertaken. Lack of end of life, diabetes and dementia care guidance and training was a particular concern.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not in place.

Inadequate



Is the service caring?

St Pauls Care Home was not caring. People and visitors were positive about the care received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respecting their dignity. People who remained in their bedroom received very little attention and at times people in the communal areas were left unsupervised with nothing to engage with.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any verbal interaction.

Inadequate



Summary of findings

Is the service responsive?

St Pauls Care Home was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The delivery of care was not person focused and people were left for long periods of time with no interaction or mental stimulation.

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Inadequate



Is the service well-led?

St Pauls Care Home was not well led. There was no registered manager in post. People were put at risk because systems for monitoring quality were not effective.

The home had a vision and values statement but we did not see the values acted on during the inspection.

People spoke positively of the care, however, commented that staffing levels could impact on the running of the home. People and visitors had an awareness of changes of management and felt that the new management team of the home were approachable.

Inadequate



St Pauls 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 22 and 26 May 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

An inspector and an expert by experience in older people's care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at

safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the three floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, including eight people's care records, four staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We spoke with 14 people living at the service, three visiting relative, eight care staff, the chef, the activity co-ordinator, two housekeeping staff, two registered nurses, the area manager and the relief manager.

Is the service safe?

Our findings

People told us they felt safe living at St Pauls Care Home. Relatives confirmed they felt confident in leaving their loved one in the care of staff at St Pauls Care Home. One person told us, “I like it here, I’m safe and fed, Who could ask for more.” Another person said, “I feel safe, very nice room and the staff are very good.” One visiting relative told us, “I can’t fault them, very kind.” Another relative said, “No problems as far as I can see.” One person told us, “They (the staff) keep me safe.” However we found there were shortfalls which compromised people’s safety and placed people at risk from unsafe care.

Whilst the provider had arrangements in place for the management of medicines, we found shortfalls in the administration and recording of medicines which were potentially unsafe. This placed people at risk of not receiving their prescribed medicines. For one person receiving insulin there was no record of insulin being given on a specific day. Staff had not identified this and checked that the person’s blood sugars were within their normal range to ensure the person’s health was not impacted on. One person’s essential medication was out of stock for seven days and the medicine causes severe side effects if stopped suddenly. No advice or guidance was in place should the person experience any side effects and become unwell. Another person had not received their Parkinson medicine as prescribed, which is required to be administered on a strict four hourly regime for maximum benefit. We found a large number (in excess of 33) of staff signature omissions (identified as gaps) in medication administration records (MAR). Nurses are required to sign on the MAR that the prescribed medicine had been administered to the correct person after it had been taken. These omissions (gaps) had not been identified by the nurse administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. Nurses when asked could not confirm whether the medicine had been administered.

We also found that people were at risk of not receiving medicine as they required it, such as pain relief due, to lack of guidance and risk assessments. These are known as PRN medicines. We looked at eight people’s care documentation that had been prescribed PRN medicines. They should only be offered when symptoms are exhibited. Such as pain relief medication. Clear guidance and risk

assessments must be available on when PRN medicine should be administered and the steps to take before administering it. People who received PRN did not all have a PRN care plan detailing when the medicine should be administered. PRN pain relief should have a corresponding pain chart so staff have the information on how effective the pain relief medication was and whether the GP should be informed to consider whether a different approach should be taken.

During our inspection we noted that some people’s morning medicines were dispensed and signed for by the registered nurse and left in people’s rooms for the care staff or the person to take later. This is not in line with The National Institute for Health and Care Excellence (NICE) good practice guidelines and does not ensure that people received their medicine on time or safely.

Not all controlled medicine was recorded correctly. The page for one controlled medicine had no name of the person to whom it was prescribed or the name and dose of the medication. This had not provided an audit trail for the safe keeping of prescribed controlled medicines. No checks by registered nurses had been undertaken since the 11 March 2015

Peoples’ risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person’s overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However not everyone’s health, safety and wellbeing was assessed and protected. For example, one person’s recent fall had resulted in a fractured limb, they returned to St Pauls Care home from a NHS hospital with a plaster of paris-which immobilised the limb. None of the risk assessments for this person had been updated to reflect this injury. There was also no guidance for staff to follow to ensure they checked the circulation of the limb or for care of the plaster of Paris. Another person was noted to have a very hot, red and inflamed lower leg. This person had previously had inflammation of their lower legs and therefore was of high risk of a recurrent episode. However the deterioration of this condition had not been pro-actively managed by using an up to date skin integrity risk assessment or by other

Is the service safe?

preventative measures. Additionally advice had not been sought from the GP or tissue viability nurse. We brought this to the attention of staff who requested an urgent GP consultation.

Risk assessments did not include sufficient guidance for care staff to provide safe care and other care plans were not being followed. For example, good skin care involves effective continence management and regular change of position. There was guidance for people in bed to receive two or four hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs in communal areas there was no change of position or toilet breaks in their care directives for staff to follow. We identified during the inspection five people had not been assisted to access the toilet or offered a change position for up to six hours. One person we spent time with was seated in a chair from 6:30 am until 3pm. No one asked this person if they would like to visit the bathroom or if they would like to change position. This was checked with staff during the inspection. One staff member said “We usually try before lunch but we have been busy.” Only two of the five people seated in armchairs and wheelchairs had a pressure relieving cushion. There was no guidance in people’s care plans to ensure staff managed skin integrity safely with regular checking and movement of position whilst in communal areas. Daily notes did not evidence that their position had been changed or their continence checked. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage.

Accidents and incidents had been documented when they occurred however there was a lack of follow up or actions taken as a result of accidents and incidents. For people who had fallen and had been unwitnessed by staff there was no record of an investigation and a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect the person from harm. Therefore the provider could not demonstrate there has been any learning from accidents and incidents.

Moving and handling practices did not always ensure people’s safety. We observed a person being supported to move from a wheelchair to armchair with the support of an under arm lift. Placing staff and the person at risk from injury. There was little verbal support or reassurance from

staff to the person being moved. This was not a safe or pleasant experience for them. We also saw a person being supported to move from a wheelchair to armchair with the support of hoisting equipment. The person was not supported safely by the two staff members. The staff had difficulty moving the hoist in to the correct position which meant that the person was left in a swinging position with no physical or verbal support from staff.

Personal emergency evacuation plans (PEEPs) were in place however these were lacking in guidance for safe evacuation. PEEPs stated the number of staff required to assist each person but there was no further information to guide staff in the safe evacuation of each person. Staffing levels decrease in the evening and night time and this was not reflected in individual PEEPs. Staffing levels especially at night would not be able to respond to the actions detailed in the evacuation plan, due to the layout of the home and only three members of staff on duty. This placed people at risk from failed emergency evacuations. This meant people were potentially at risk from harm from unsafe procedures.

All of the above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing comprised of five care staff in the morning in addition to the registered nurse. The staffing levels decreased in the afternoon to four care staff and a registered nurse. The manager was supernumery to the staffing levels. Two waking care staff provided support at night with one nurse. At the time of our inspection, the majority of people living in St Pauls Care Home needed support with their needs. People required two staff to assist them with all personal hygiene needs and assistance with mobilising. We were told the provider used an informal staff ratio of 1 staff member to five people, this did not reflect the documented needs of people.

On the day of the inspection there had been an error made and the morning shift was one care staff member short. This put added pressure on staff to deliver care. This meant that the delegation and number of staff was inappropriate to meet the needs of the people at this time. We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Personal care to get people up for the day was still being undertaken at midday and this was not always people’s individual preference. This meant that people had not had an opportunity to enjoy

Is the service safe?

their morning as they were waiting for staff. One person told us, “More staff is needed, I do have to wait for staff at times.” Another person said, “I feel rushed sometimes as staff need to help other people too, but everyone takes their turn.”

Care delivery records told us that people were not receiving baths or showers as their preferences stated. For some people there was nine to ten days where they had received a wash but no offer of a shower or bath. Staff told us, “Well we only have one shower and the bath is not working. So we can’t always run them down to the shower on the ground floor, there’s no time to spare.” Another staff member told us “It’s difficult to get things done but we do a good job despite being in need of more staff.”

Staff struggled to provide care and to supervise people in communal areas. We observed people left in the lounge area without interaction as staff were undertaking personal care for other people. At times people sat without any background music, the offer of the television or a book.” We also noted that people did not have access to a call bell, which isolated them further. Staff were not able to offer assistance to meet people’s individual needs.

Accident and incident reports recorded a number of unwitnessed falls of people in communal areas and bedrooms, this indicated that staff were not present and people were therefore not adequately supervised.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview before they started work, the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed by the provider of St Pauls Care Home and bank nurses all had registration with the Nursing Midwifery Council (NMC) which were up to date.

There were a number of policies to ensure staff had guidance about how to respect people’s rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One staff member said “I have raised concerns before and the previous manager sent an alert to social services, I wouldn’t hesitate to do it again, people need us to be alert and knowledgeable.”

Is the service effective?

Our findings

People spoke positively about the home. Comments included, “I’m looked after.” “The carers are very good.” However, we found St Pauls Care Home did not always provide care that was effective.

Staff were not working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. We found however that there were people who lived with a diagnosis of early dementia and some people who were not able to speak using words. We found mental capacity assessments had not been undertaken. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people’s mental capacity did not record the steps taken to reach a decision about a person’s capacity. We asked the staff to talk us through how they completed the mental capacity assessments. They were unable to tell us how they undertook the assessments or the steps needed. We were informed, “It’s about asking them and making sure it is what they want.” Staff were unable to tell us about how decisions for bed rails were made, for example consenting to photographs about bed rails or about whether people could use a call bell. We saw documented that one person did not have the capacity to use a call bell and therefore did not have one. There was no rationale given as to why or what alternative could be put in to place. This told us mental capacity assessments were not undertaken, were not decision specific and were not recorded in line with legal requirements.

Training schedules showed us that not all staff had received Deprivation of Liberty Safeguards (DoLS) training or MCA 2005 training. Care staff we spoke with had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, “We give them a choice of what they can wear, I hold it up for them and I look at their reaction.” Another staff member said, “We get to know people really well and know what they want.”

In March 2014, changes were made to the Deprivation of Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the

person from harm. We were told that there was no-one currently in need of a DoLS. The use of bedrails had not been considered as a deprivation of people’s liberty. This demonstrated that DoLS procedures were not in place or understood. There were no individual mental capacity assessments for people living at St Pauls Care Home on how their freedom may be restricted or what least restrictive practice could be implemented.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The meal service at St Pauls Care Home was not a shared experience or made to feel like an enjoyable event for people. It had become a task rather than something to be looked forward to. There were no dining tables available for people to eat at if they should choose to. People either ate in their room or from a small table in front of their lounge chair in the communal day room. Staff told us that people didn’t want to eat at a table and therefore didn’t offer them the opportunity. One staff member said, “No one has ever asked, people don’t want to.” One person experienced difficulty in managing to eat their meal due to poor positioning in a wheelchair. This person told us, “I would be able to eat more comfortably and easier at a dining table.” We spoke to one person who said, “I used to always look forward to meals at home, because it’s where we as family used to talk about our day. It’s just fuel now.”

Seven people remained seated in the lounge area and either had small tables to eat their meal from, or received one to one support to eat from their armchair/wheelchair. Four people received support from staff, this was done in a perfunctory manner with no eye contact or conversation. People ate without aids that would enable them to eat without struggling, such as plate guards and angled cutlery. When asked staff told us it was not routinely used. Condiments such as pepper and sauces were not offered. We observed that the majority of people were given a plastic beaker/cup to drink from. One person commented “It makes my tea taste funny.” Not everyone required plastic crockery and there was no choice offered.

The meal service started on the ground floor and then trolleys were taken up with food. Hot trolleys were not used. People that required assistance were served at the same time, and this meant that whilst other meals were served to people food was cooling. Therefore people did not always get a hot meal. One person said, “I haven’t had a hot meal in four years, always luke warm.”

Is the service effective?

People who ate in their rooms were checked by staff intermittently to ensure they were eating, but this was not consistent on all floors. We observed people sitting with food uncovered, waiting for staff to assist or prompt them to eat. This meant their food was luke warm. Staff assisted people in bed to eat by standing and reaching over bed rails. There was little interaction and it was not an enjoyable experience for people.

The meal was attractively presented by the cook, who was knowledgeable of people's specific dietetic requirements such as soft, fork masheable or pureed. Pureed food was attractively presented and recognisable as meat, vegetables and potato but staff mixed the food together before they helped people to eat. It was then unrecognisable and people were unable to identify the food they were eating. One staff member said "If I do it separately they get just one taste, surely it is better if it is mixed up."

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from not eating and drinking. Some records were incomplete and not totalled, and therefore would not be an effective way of monitoring how much they had eaten or drunk. We identified five people whose records indicated a fluid intake of less than 500mls in 24 hours. Staff had not recorded if a refusal had been followed up and people were offered a drink at different times or whether it had been identified to the nurse.

One person had been receiving sub-cutaneous fluids as they were unable to drink. Subcutaneous fluids are prescribed by the GP and administered via a small needle just below the skin. There was no record of this on their fluid chart or the MAR record. When asked staff were not sure of when it had been started or discontinued. There was an entry in the daily notes that stated family had asked for it be stopped, but no rationale or discussion recorded with the GP.

The staff had not ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Some staff told us they were behind in some areas and this was already known to the organisation. Whilst training was available it was not effective in all cases. We observed poor practice in moving and handling people, assisting people with their food and in safe medicine practices.

We were told staff received an induction programme which lasted a month and on-going training support. We were also told that newly appointed staff shadowed other experienced members of staff until they and the manager felt they were competent in their role. However this was not evidenced from the duty rota or from the induction programme which was unsigned by a senior member of staff. One staff member made contact with us following the inspection and told us, "I feel that I have lost my confidence, I feel unsupported and not fulfilling what I was trained to do." Another staff member said, "I struggle to do training due to the hours I work."

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said "Supervision has not been happening." Staff records of supervision confirmed that staff supervision had not been undertaken in six months or more for most staff. The supervision records were poor in quality and not effective for its purpose. Staff told us they felt unsupported at present due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed.

We looked at training records and saw that staff accessed training via the internet from an e-learning provider. Training records indicated that fundamental training for all staff was not up to date. For example, MCA, safeguarding, health and safety. Service specific training, such as end of life care, dementia, and diabetes had not been undertaken by all staff. We saw care delivery for people who lived with dementia was not always stimulating and person focused and people with diabetes were not always supported in a way that maintained their health. This impacted negatively on people's well-being.

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service effective?

People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff recognised

that people's health needs could change rapidly especially for people living with a deteriorating illness, such as Parkinson's disease. One staff member told us, "We recognise when people's health is declining."

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact were given very little time and attention throughout the day. People spoke positively of care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived at St Pauls Care Home. Comments included, "I see staff smile but they say very little to my mum," and "I think that staff are kind, but I do wish they would chat to the residents more, I visit my parent but spend time chatting to other people as staff don't."

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain people's dignity. One person was complaining of discomfort in their legs and this had not been acted on by staff until we brought it to their attention. We were told that this person's legs should have been elevated to reduce swelling but this had not happened. Staff occasionally came to this person and asked if they were "ok" but did not then offer any reassurance or offer pain relief. During the morning an odour was identified in the lounge, staff were seen to lift people's clothing and check their continence, without ensuring their privacy. This was not done in a discreet manner nor were people taken to the bathroom to do this in a more dignified manner. During this time another staff member came in and sprayed air freshener without any consideration of people's feelings. This impacted on people's dignity.

In one communal bathroom there were suitcases and bags with a person's personal belongings such as letters, cards, photographs and clothing. They had been moved to the bathroom in January following the person's death and staff had not ensured they had been returned to family or moved to a place of safety. This did not demonstrate respect or that the organisational policies for confidentiality had been followed by staff.

People's dignity was not always promoted in the communal lounge when they were helped to move, as a person's under clothing was displayed whilst being supported in a moving and handling hoist. No attempt was

made to offer privacy during the procedure. Some people's hair and personal hygiene had not been attended to a standard wished by individuals. One person said, "my hair hasn't been washed for a while, I do like clean hair." People were not offered a choice of a cup and saucer and were instead given a plastic beaker. We asked one person if this was their preference and were told, "No I just get this, would be nice to drink out of a proper cup, drinks tastes better in a decent cup."

People's preferences for personal care were recorded for each person but not always followed due to lack of shower and bath facilities. This was also as a result of managers not reviewing staff deployment whilst the bath and showers were repaired. We looked at a sample of daily notes, which included documentation on when people received oral hygiene, bath or a shower. Documentation showed us that often people would not receive a bath or a shower in 17 days but instead had received an assisted wash. The care plan did not state that this was people's preference or if it was due to lack of working bathing facilities. One person had only received one shower in 10 days. The person told us "It would be nice to have a lovely shower, but I can't complain, because staff help me by washing me." We saw that people could go a week without receiving oral hygiene. One person said, "I have to remind people to clean my teeth. However we could not find records of oral hygiene within the daily notes. We could therefore not tell if people received regular support to bath or shower as they wished or if they received oral hygiene as identified they wished in their care plan.

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, whilst two visitors told us they had been. The care plans gave information about the person's family history, their preferences, relationships, family and key medical information. The information however was not always easy to locate. Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. However when we reviewed the care files we noted that not all contained specific details to provide person specific care. For example, what time people preferred to get up or go to bed. The directives we saw in care plans had not been updated to reflect their changes to their health. One person who was on continuous bed rest still had their preference recorded for getting up at 7a.m and going to bed at 10pm.

Is the service caring?

People were not always supported to be independent and make day to day decisions. Some people told us they did not feel listened to. One person said “I sometimes feel like I’m not as important as other people, I feel cut off from life and don’t have much choice in what happens to me.” We asked staff how they supported people who felt lonely and were told “We try and make time to talk through things.” However this was not recorded or included in people’s care plans and risk assessments. There was no reflection of conversations between staff and people about what they want from life whilst living at St Pauls Care Home, such as people and their social aspirations.

We observed one person in a wheelchair moved without being asked into a position facing a wall. We waited for this person to be moved but staff did not move them. There was no explanation given, and they remained there for three hours with no interaction. We asked the reasons for the persons’ positioning and were told “The fish tank used to be there and they loved watching the fish.” However there was no fish tank and hadn’t been for a while. When we asked why this person was facing the wall was so isolated, staff did then give the person a book and move their position to facing other people in the room. Whilst staff knew of this person’s love for watching fish they had not thought to use this knowledge to provide another form of stimulation and engagement.

Relatives told us, “They keep us well informed, I always ask though.” Another relative said, “I have concerns, we are not always consulted and involved, I am worried that my relative doesn’t get supported to be independent. Once seated that’s it for the day, they could walk if the chair was a better height for them.” This was discussed during our inspection and staff looked at finding suitable seating to enable the person to be able to move freely when they wanted. It was confirmed that this would be a priority. Staff told us, “We support people to do what they want.” However we did not see staff ask and involve people in their everyday choices, such as offering a selection of beverages, seating preferences and meaningful individual activities.

People were not treated with dignity and respect in ensuring their personal care needs were met consistently. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The manager told us, “There are no restrictions on visitors”. A visitor said, “I visit regularly and stay as long as I want, I am always made welcome and feel comfortable visiting.”

Is the service responsive?

Our findings

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not responsive to individual needs.

Communication and social well-being was an area that we identified as a concern as 11 people were isolated in their bedrooms (four) and in the lounge areas with little interaction. During our inspection we noted at times during the morning and just after lunch when there were no staff in communal areas and people were left with no television on or radio for up to an hour. There was no rationale given by staff or any evidence that this was people's choice. Three people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed the tasks but did not use this one to one time to chat or offer reassurance. One person could communicate with us very clearly. We returned to this person throughout our inspection and saw that apart from they received no other social interaction from staff. We observed staff waking this person for lunch by awakening them with very little verbal interaction. The staff member assisted the person with their meal over the bedrail from a standing position and there was no eye contact or verbal interaction made throughout this procedure. It was a sad and solitary experience for the person, who told us they missed company and were 'fed up and lonely.'

Care was not always personalised to the individual and did not include important changes to their health. For example, one person had been placed on end of life care following discharge from hospital. The person's care plan had not been updated to reflect this and had been last reviewed in April 2015 before their admission to hospital. The care plan lacked information required of significant changes to this person's health, such as decreased mobility. We also found no guidance in place for pain relief for bony injury following a fall. There was no information to guide staff on the use of sub cutaneous fluids and how to ensure the needle site was clear and free from infection. The NICE good practice guidance for the use of sub cutaneous fluids recommends a chart that staff complete to change the site of the needle, checking for redness and inflammation. This was not in place. Fluid charts for this person were not accurate and did not reflect the use of the fluids. The staff had not put an

end of life care plan in place to guide staff in the delivery of holistic end of life care for this person. Staff therefore had not been responsive to the changes in this person's care delivery and we could not be assured that the care delivered was reflective of their current needs.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However the care plans lacked details of how to manage and provide specific care for people's individual needs. For example one person with diabetes was on a sugar free diet and receiving insulin. The person's blood sugars were very erratic and had not been acted on or specialist advice sought. There was no individual baseline normal blood sugar recorded to advise staff of the person's normal range. Staff told us that the person was non compliant with their diet but this was not being managed and staff were not responsive to the fluctuating blood sugar levels. None of the care plans for people with diabetes contained information of how staff could identify hyperglycemia (high sugar levels) such as increased thirst or hypoglycemia (low sugar levels) such as lethargy and dizziness.

People's continence needs were not always managed effectively. Care plans stated when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. Every person has an individual need and these were not recorded or explored to promote continence. Mobility care plans lacked guidance for staff in maintaining what mobility people had and encouraging retaining their mobility. For example, encouraging a mid-morning and afternoon stroll or just standing to relieve pressure. One visitor said, "My relative can walk but he's not encouraged to."

Wound care records for people were not all up to date and lacked detailed instructions to monitor and redress the wound as to the effectiveness of treatment. One person had a dressing on their leg that had last been redressed a month before on the 24 April 2015. The agency nurse on duty was not sure if it was due to be redressed or of the status of the wound. There was no reference of the wound being dressed in daily notes.

There were people who were on a fluid monitoring chart as they had been identified as risk from dehydration and unable to manage to drink independently. Three people

Is the service responsive?

did not have a chart in place for the day of the inspection, we identified this at 2pm. The previous day's fluid intake had not been totalled and therefore staff were not aware if they were managing the risk of dehydration effectively. For one person the fluids recorded was 300mls in 24 hours. This had not been assessed and monitored as a sufficient amount of fluid for this person to retain their health. The suggested minimal amount of fluids in 24 hours for an adult is 1000mls (dependent on size and health) The daily records and handover sheets had not identified this as a concern nor a plan to prompt drinking instigated.

Care plans reflected some people's specific need for social interaction, but these were not being met. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken. The activity person was enthusiastic about their role, but told us that it was difficult to ensure everyone received an opportunity for activities due to the high percentage of people who remained in their room. Staff said people preferred to stay in their room and so no longer offered to take them to the communal lounge. We spoke with one person and asked if they could help us by telling us the name of the person sitting in the lounge with them. We were told, "I don't know, we have never been introduced." We found that people despite living with other and sharing events didn't know each other's names. One staff member told us, "I never thought of it like that."

The records showed us that the activity co-ordinator spent time on one-to-ones sometimes but this was not regular. This also meant if the activity co-ordinator was visiting people in their room, the people in the communal areas were left watching television with no other meaningful activity. People we spoke with enjoyed their time with one to ones but confided it was not as often as they liked.

Activities promoted were not reflective of people's individual interests and hobbies. One person told us that scrabble would be good, 'get my mind working' whilst another would have liked to play cards. Whilst we saw that visitors were welcomed during the day and there were some activities on offer, people's individual social and welfare needs were not being consistently met.

The evidence above demonstrates that delivery of care in St Pauls Care Home at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a notice board in the reception area that showed people enjoying visits from outside entertainers and pet visitors. We also saw that people's birthdays were celebrated. People told us that events were fun and they needed more of them. One person told us they were going on a picnic soon which they were looking forward to.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format. One person told us "I would ask my daughter to complain, I'm not sure I have seen a complaint form." Another said, "I was given one when I came here but not sure if I still have it." Most people told us they felt confident in raising any concerns or making a complaint. One person told us, "I'm happy to complain if I need to, I have complained and the staff rectified the problem." There had been one complaint since January 2015 which was still on-going, documentation confirmed complaints were investigated and feedback was given to the complainant.

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be approachable, open and supportive. People told us; “Friendly and kind,” and “Helpful.” A relative said; “I think the manager leaving has left a gap, because it’s been a little hard to find out things, but everyone tries hard.” A staff member commented; “The new management team are supportive, and I think everything is good.”

There was no registered manager in post. The registered managers’ post has been vacant since March 2015. An organisational relief manager has been in post since the middle of May 2015 and will stay to manage St Pauls Care Home until a registered manager is recruited.

A new senior new management team came in to post in January 2015 and were undertaking organisational audits which had identified some of the shortfalls found but work to improve had not yet progressed.

Whilst there were some quality assurance systems in place, they were not all completed and had not identified the shortfalls we found. We found that people’s safety was potentially at risk from poor medication practices. Some care plans were lacking in specific information that had the potential to cause harm to the individual. We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints. We also found that people’s nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink. The care plan audits had not identified that people’s specific health needs were not accurately reflected in their care plans, for example management of wound care, end of life and continence. The environment and equipment for people who lived at St Pauls Care Home was not suitable to support people safely and ensure people’s individual needs were met. The lack of communal working bathrooms had not been identified by an audit

People had not been protected against unsafe treatment by the quality assurance systems in place. This was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. Staff were able to tell us, “We work to ensure that people receive the care they need, the

vision is person centred care.” Staff we spoke with had an understanding of the vision of the home but from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. Staff however spoke positively of how they all worked together as a team. They said they supported each other and helped out on other floors if they were busy, “When it’s busy we all muck in, get the work done.” Staff mentioned a lack of leadership recently and said some nurses seemed ‘lost’ and that things were not being done as they felt they should. Discussion with nurses told us that they felt unsupported and disempowered.

People, staff and visitors said that communication and leadership had improved within the home and the atmosphere was pleasant. Staff and visitors had an awareness of the management team and felt that the morale of staff had improved. As we saw on the day of the inspection the staff worked hard but shortcuts in care delivery were noted due to time constraints and staff shortages. This meant people did not always receive the care they wanted and required.

The area manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at St Pauls Care home to share their thoughts, concerns and ideas with them in order to enhance their service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, “I feel this is a positive move forward, recently I have felt that my grumbles didn’t get taken forward, but I have now met the new person in charge and I feel confident that changes will be made.”

Staff meetings had not been held regularly over the past six months, but had been reinstated and we were assured that regular meetings would be held whilst changes to the management structure changed. The relief manager said, “It’s important to build up staff confidence and work with them whilst improving the service, we know that there is hard work ahead but regular meetings with residents, visitors and staff will provide a forum for open communication and instil confidence.”

Is the service well-led?

Daily handovers were held at the end of staff shifts and we attended two of them. The quality of the handover was not effective and did not give the agency nurse all the information they required to run the shift efficiently and safely. They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, investigations and supervision. We saw evidence of this during our inspection.

One staff member said that the culture was already changing, and they were being encouraged and supported to question practice, “We have been asked for suggestions on how to improve and have raised suggestions about staffing levels, the manager listened and I felt supported.”

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 11 (1) (3) (4) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met. Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

warning notice

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

The provider had not ensured the proper and safe management and administration of medicines including as required medicines. Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.

Staff had not received appropriate training, professional development and supervision.

This section is primarily information for the provider

Enforcement actions

Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice