Barchester Healthcare Homes Limited

Westgate House

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8, 10 and 17 August 2016. The first day of the inspection was unannounced.

At the last inspection in June 2015 the service was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were at risk due to poor infection control measures at the service. At this inspection we found these issues had been addressed and the service was meeting the requirements of Regulation 15.

Westgate house provides accommodation and nursing care to older people living with dementia and younger people with nursing needs. The service is registered with the Care Quality Commission to provide care for up to 80 people, 79 people were living in the home at the time of our inspection.

The home had a registered manager in 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 2008 and associated Regulations about how the service is run.

People were not always protected from the risk of avoidable harm as risk assessments lacked details required to ensure they were supported safely.

The systems for ensuring the safe management of medicines were not used consistently across the service. The guidelines in place for people who had been prescribed medicines on an 'as needed' basis were insufficient and people did not have individual medicines support plans or risk assessments.

People told us, and records confirmed, the service did not always have enough staff on duty to ensure people's needs were met. Activities staff were used to cover gaps in the rota and this meant people did not always have access to activities. People and their relatives said that activities provided did not meet the needs of people living with dementia, or those who could not leave their bedrooms. We have made a recommendation about activities.

People told us they felt safe, and staff were knowledgeable about safeguarding adults from harm. However, the service was not always raising safeguarding concerns as required.

Staff were recruited in a safe way and received the support and training they required to perform their roles.

Records of consent did not demonstrate that the service was seeking consent in line with legislation and guidance.

People and their relatives gave us mixed feedback about the food provided by the home. The home was working with people, their relatives and the provider's hospitality team to improve the range of food

provided to ensure it met people's preferences.

People were supported to access healthcare services as required.

People's care plans were not consistently personalised and it was not clearly recorded that people and their relatives had been involved in writing and reviewing plans of care. Relatives told us that changes were not always made when requested.

The home had a robust policy for complaints and records showed complaints were responded to in line with the policy.

People told us they thought staff were caring, and they were treated with dignity and respect. People were supported to maintain their personal relationships and practice their religions where they wished to do so.

People and their relatives gave us mixed feedback about the openness and availability of the registered manager. Some people found her easily accessible but other people said she was not available to them.

The provider completed regular and robust audits of the quality of care provided. However, the actions in place to address issues identified were not effective, as the same issues were identified repeatedly and during our inspection.

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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People's risk assessments were not robust and did not contain the details required to ensure staff provided support in a safe way.

People's medicines were not always managed in a safe way as records were inconsistent and guidelines for staff were not in place.

People told us they felt safe, and staff were knowledgeable about protecting people from harm and safeguarding adults. However, the service was not always identifying safeguarding issues appropriately.

There were not always enough staff deployed to ensure people's needs were met.

Staff were recruited in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not routinely record where people had appointed others to make decisions on their behalf. Consent to care was not recorded in line with legislation and guidance.

Staff received the training and support they required to perform their roles.

People and relatives gave us mixed feedback about the food. The home ensured that people were supported to eat and drink sufficient amounts to maintain a balanced diet.

People were supported to maintain their health and have access to healthcare services when required.

Is the service caring?

Good

The service was caring.

People told us the staff had a caring attitude.

Care plans contained details of people's pasts and key relationships.

People were supported to follow religious faiths if they wished to do so.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not personalised and records did not show that people had been involved in planning their care.

Relatives told us changes they requested did not happen.

Activities provided by the home did not meet the needs of all people living there.

The home had a complaints policy and complaints were responded to in line with this.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The audits completed by the provider identified the same issues repeatedly over time. Actions taken to address these issues had not been effective.

People and their relatives gave us mixed feedback regarding the approachability and openness of the registered manager.

The home had a clear management structure and systems in place to escalate concerns.

Westgate House

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 8, 10, and 17 August 2016. The first day of the inspection was unannounced.

The inspection was completed by two inspectors, a specialist advisor with expertise in mental health nursing and dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for someone living with dementia.

Before the inspection feedback was requested from local authority commissioning teams and the local Healthwatch. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we already held about the service, including statutory notifications we had received and previous inspection reports.

During the inspection we spoke with seven relatives and eight people who lived in the home. We also spoke with 17 members of staff including the registered manager, the regional manager, the deputy manager, the administrator, the activities coordinator, the chef, the housekeeper, five nurses, two senior care assistants and three care assistants. We looked at the recruitment and supervision records of 13 members of staff, and the training records for the service. We reviewed the care records of 17 people including plans of care, risk assessments and medicines records. We also looked at various audits, policies and documents relevant to the management of the service. 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.

Inadequate

Is the service safe?

Our findings

At our last inspection of the home in June 2015 we found people were at risk of infection due to poor infection control practices at the home. At this inspection these issues had been addressed. The housekeeper showed us audits of cleaning completed, the premises were visibly cleaner and there was no malodour present. Areas of the home, including some bedrooms and carpets were tired in appearance and required redecoration and updating. The housekeeper showed us they had records in place and a schedule for requesting new furnishings and carpets for bedrooms.

Care files contained a range of risk assessments to mitigate against identified risks including choking, malnutrition, mobility, moving and handling, tissue viability, communications, personal hygiene, continence care and behaviour. The measures in place to reduce and manage risks were generic and were not specific enough to give staff the details they required to appropriately manage risks. For example, the moving and handling risk assessments viewed listed the manoeuvers people required support with, whether they required staff supervision or support and how many staff were required. They did not consistently provided details of the equipment required to complete the manoeuver. Where hoists were used they did not provide details of the specific sling, or the person's preferred position within the sling.

One person was described as having particularly complex moving and handling requirements, including specific repositioning requirements and the support of four members of staff. However, their care plan and risk assessment did not provide sufficient detail to support them safely. It stated, "Staff members to assist [person] at all times using a sliding sheet for repositioning. Four staff members also for turning." In terms of this person's positioning and posture needs the plan stated, "A pillow to support right arm and three pillows to support their arm and chest." This does not tell staff how to support this person with their positioning and moving and handling needs in a safe way. Another person was identified as being at risk of falls. However the care plan stated, "Staff should be up to date with manual handling training as well as skilled when using equipment." There were no specific measures relating to this person's individual falls risks and how these were managed.

The ground floor of the home provided care to people living with dementia. People living on this floor could present with a range of behaviours which challenged staff and other people living in the home, including verbal and physical aggression. Risk assessments and plans to support people to manage their behaviour lacked detail and did not contain measures to manage the risks associated with these behaviours. For example, one person was receiving one to one support and staff informed the inspector this was due to their behaviour. The person had a behaviour support plan in place, however the plan stated, "On behaviour chart. He wants to be respected." The sections related to triggers and patterns of behaviour was blank and there were no strategies in place to respond to any incidents. Another person had recently hit another person and although the care plan described their behaviours, there was no behavioural care plan in place and no strategies in place to manage the risk of further incidents. This meant the service was failing to manage the risks associated with behaviour which can challenge people, staff and the service.

People living in the home had a range of complex medical conditions and required support to take their

medicines. The home did not complete individual medicines care plans or risk assessments for people. The home relied on the knowledge and experience of nursing staff to mitigate the risks associated with medicines administration. This was not sufficient as each nurse was responsible for administering medicines to a minimum of 12 people. On the ground floor two nurses were available to administer medicines to 31 people in the morning. However, during the afternoon and evening only one nurse was available. Observations showed that it took over two hours to complete the lunch time medicines round and this involved one nurse staying beyond the end of their shift to support medicines. During the medicines round one of the nurses was subject to distractions as they were the point of escalation for any other issues on the floor. It was in recognition of their colleague being subject to these distractions that the other nurse stayed late to support with medicines This was discussed with the registered manager and regional manager who advised they would deploy the deputy manager to assist during afternoon and evening medicines administration rounds. Without a written medicines plan or risk assessment this meant the risk of errors, or people not being supported in the best way to take their medicines was not mitigated. One relative visiting the service was visibly distressed that their relative had not taken their medicines and described how there were specific ways to encourage them to take their medicines. As there was no medicines plan, the staff had not had access to this information and had not known how to encourage this person to take their medicines.

The home supported people to take medicines prescribed on an 'as required' (PRN) basis. Where people were prescribed medicines on a PRN basis there should be guidelines in place to inform staff when these should administered. The medicines records of seven people were reviewed. The guidelines in place for PRN medicines were incomplete or insufficient in the files viewed. For example, one person was prescribed co-codamol which is used as pain relief. The dose was not correct as it stated 500mg which is not a correct dose for this medicine. The instructions were, "Give one or two orally in the morning, lunchtime, teatime when required." There was no information for staff to know when the person should be offered one or two tablets. In addition, the plan was meant to be reviewed monthly but had not been reviewed since June 2016. This meant it had not been reviewed for two months at the point of inspection.

Another person was prescribed tramadol PRN for pain relief. The dosage of this medicine was not completed, nor was the maximum dose. This was discussed with the nurse in charge for the unit who advised this medicine had been discontinued. There was no record of this on the person's medicine administration record. A third person had been prescribed morphine on a PRN basis. There were no guidelines in place to inform staff when this person might require morphine.

The home supported people to take controlled drugs. The administration of controlled drugs is strictly regulated to ensure the safety of people who used the service. The recording of the administration of controlled drugs was inconsistent across the service. The home used a triple recording system for the administration of controlled drugs which were prescribed in the form of transdermal patches applied to the skin. This involved recording administration in the controlled drugs book, the medicines administration record and on a separate sheet which recorded the location the patch was applied to. One person's records showed inconsistencies between these records, with different dates on the medicines administration record and the controlled drugs book. This meant there was a risk that people were not getting their medicines as prescribed.

The above issues regarding risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing rotas for two floors were reviewed. On one floor the rota accurately reflected the staff deployment on the day of our inspection. On one floor the staff deployment was one care assistant less than

the rota. Senior staff told us they had used the activities coordinator to cover for this by providing one to one support to a person. Records of audits completed by senior staff showed the service worked with staffing levels below those calculated by its staffing tool. An audit completed on 4 August 2016 showed the ground floor had been short of three care assistants during that week. The arrangements for covering unexpected staff absence were discussed with the registered manager. They told us the service used bank staff to cover absences and rarely used agency. The registered manager also said, "It does happen to be two care assistants down." When asked if the service sometimes worked short they said, "To be honest it does happen."

People and their relatives also expressed concern about the staffing levels at the home. One relative said, "I don't think they have enough staff working here, no one checks up on my relative." One person told us, "At weekends there is not many staff, they struggle." Another person said, "They [staff] are doing really double work, they should have more staff." People and their relatives were also clear that despite feeling there were not sufficient staff, they did not feel rushed during their care.

All of the five nurses we spoke with told us they did not think there were sufficient nurses on duty to provide high quality care. This was because the nurses were responsible for writing and updating care plans and risk assessments as well as all medicines and nursing tasks. Where nurses were also unit leads, they were also required to complete management tasks including meetings and support for staff during their shifts. One nurse said, "I don't have time to do all the paperwork." Another nurse said, "We are really struggling [with staffing levels]. We have asked if we can have two nurses on the floor because with all the documentation it is really too much. I rarely get to take a break and sometimes it makes me stressed, which can make me get stressed with the care assistants, which makes them stressed too." Two other nurses also told us they rarely got to take a break, even when working a 12 hour shift. This meant there was a risk that people would receive unsafe care from staff who did not have capacity to complete the work required of them.

The above is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe at the home. One person said, "I am safe here, I have no concerns, the staff make me feel safe." A relative told us, "I think my relative is safe and the nurses surely make me feel that way." The home had a robust policy regarding safeguarding adults from harm and staff had received training on safeguarding adults. Staff told us they would report any concerns they had regarding abuse or avoidable harm to their manager.

The home had two folders for recording safeguarding concerns and incidents. The safeguarding folder contained records of the alerts raised by the home. The records from April 2016 until August 2016 were reviewed and showed the home had raised alerts regarding pressure wounds acquired by people living in the home. The records from the incidents and accidents folder from July and August 2016 were also reviewed. These showed there had been three incidents where one person had assaulted another person in the home. These had not been raised as safeguarding alerts despite being incidents of abuse. This meant the home was not consistently identifying safeguarding concerns and raising alerts with the appropriate authorities. This was discussed with the registered manager and the deputy manager who then raised the alerts as required with the local authority. The registered manager also told us they had requested additional training for staff from the local safeguarding team.

Staff told us and records confirmed the home carried out checks on them before they were employed. These included providing proof of identification, criminal records checks, proof of the right to work in the UK and references. The provider's policy on staff recruitment stated that a minimum of two references were required

for each employee. Although two references were in place for 11 of the staff files checked, there was only one reference for one person. Their application had listed two references. This was discussed with the registered manager who spoke with the relevant staff member and told us they believed two references had been obtained but they were unable to explain why it was not available to view at the service. A copy of the reference was supplied after the inspection.

The recruitment policy stated, "In certain circumstances it is not always possible to get a reference from a former employer. In these circumstances a character reference can be acceptable. When getting a character reference, it is important that the reference is from an appropriate source. Character references should not be received from family members or friends. They should be deemed as impartial." The service had not always followed it's recruitment procedures as two staff had provided references from family members. At our last inspection we had found similar issues with recruitment processes and references which have not been addressed despite assurances at the time that they would be. After our inspection the service collected an appropriate character reference in line with their policy for one of these staff.

Requires Improvement

Is the service effective?

Our findings

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). We checked whether the service was working within the principles of the MCA.

Records showed the home had submitted appropriate applications for DoLS and maintained a computerised system for ensuring that records had been kept up to date. However, records relating to people's capacity to consent to their care, or whether or not they had consented were less clear. Only one of the care files viewed had been signed by the person it related to. In one person's care file the section for "legal status / capacity" was blank. The care plan relating to mental health and cognition stated, "Oriented to self but disorientated to place and time. Unable to retain information." The person's advanced care plan showed their relative had been involved, and stated "yes" to the question asking if that relative had legal authority to make decisions. However, the person's name was not on the list of people who had a legally appointed person in place to make decisions on their behalf. The person had not signed their care plan so it is not recorded that they had consented to their care and there was no recorded capacity assessment or best interests decision making process in the event they lacked capacity.

In another care file it was stated, "[named person] is my decision maker." However, the sections regarding power of attorney were blank. There was a capacity assessment within the file, however, it did not state the decision it related to, the date upon which it was completed or the reason why it was completed. The inspector asked the registered manager to provide a list of people who had legally appointed decision makers under the Mental Capacity Act 2005. The registered manager requested additional time to complete this list as they had to request the information from the funding local authorities. The service should already have held this information to ensure that only people with the legal right to do so are making decisions regarding care and treatment. As the service did not have this information easily available at the point of inspection, there was a risk that consent was not being sought in line with legislation and guidance.

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

People and their relatives gave us mixed feedback regarding whether they felt staff were trained to do their jobs. One person said, "I feel confident on what staff are doing here, they must be trained. A relative said, "I feel staff know what they are doing." However, another relative said, "I feel there is a void in expertise. They can pass a tick-box assessment but can't apply those skills." Another relative said, "I don't think they were trained on [specific care task]. I don't think carers are trained to consider the consequences and impact of things."

Staff told us and records confirmed they undertook an induction training programme on commencing work at the home. This involved classroom based training covering areas including moving and handling, safeguarding adults, infection control, health and safety and dementia care. The registered manager told us, "Care staff are in class for about three weeks doing induction." For care and nursing staff the induction then involved two weeks working at the service on a supernumery basis. This gave them the opportunity to shadow more experienced members of staff to learn how to support individuals. The registered manager told us and records confirmed that new staff completed the care certificate. The care certificate is a nationally recognised qualification that gives care staff the foundation knowledge they require to work in care settings.

The registered manager told us that staff were expected to complete annual refresher training in core subjects deemed mandatory by the provider. For care and nursing staff this included training in cardio-pulmonary resuscitation, customer care, duty of candour, dysphasia and choking, fire safety, food safety, infection control, moving and handling, the Mental Capacity Act (2005) and DoLs. The provider monitored staff training with the use of a computer spread sheet which showed when staff last had training. Training for staff that was in date was highlighted in green, this turned to amber when the next training due, and to red if it became overdue. This helped the provider identify when staff were due to have training. Records showed that over 90% of staff training was in date on the day of our inspection.

Staff told us, and records confirmed that staff had regular supervision. Records showed this included discussions about learning and development. It included a review of the last supervision and an action plan for staff. For example, how to improve infection control, how to support people and the importance of staff hand over of information. Records showed that during our inspection 65% of staff had received supervision in line with the provider's policy. After the inspection, the registered manager sent an update which showed 70% of staff had received supervision. Those staff who had not received supervision in line with the policy, had received supervision within five weeks of the date the report was submitted. This meant staff were receiving appropriate support to perform their roles.

Observations around the service showed that people were offered drinks, fresh fruit and snacks throughout the day. Where people required their food to be fortified or to have a modified texture this was clearly recorded and supported. The service produced a four weekly menu with various options for people to choose from. The chef also showed us that they provided one person with a personalised menu devised by their family in order to meet their cultural needs. Observations of mealtimes showed that people were provided with the support they needed to eat their meals.

Feedback about the food was mixed. One person said, "The food is good, I don't have any problem with that and I also get plenty of choice." Another person said, "When I like the food I am more than happy to eat it, but when I don't like it I tell them and I get choices." This contrasted with feedback from other people and relatives. One person said, "I don't get enough choice, all the time the food is the same. If there is something I don't like I tell them I don't like it and they don't actually give me something different." A relative said, "I have to cook food and bring it in for [my relative] as they do not like the food from here, it has no taste." In response to the mixed feedback regarding the food, the provider's hospitality manager visited the service and worked with the chef to redesign the menu. The registered manager recognised that it was a challenge to meet the diverse dietary preferences as there were 14 different cultural preferences within the service.

People's healthcare needs were identified in their assessments and care plans. Records showed that people had access to GPs and other relevant health professionals including speech and language therapists, and psychiatrists. Both staff and relatives raised concerns regarding one of the GPs who visited the service. This was discussed with the registered manager who was able to show records regarding meetings to discuss

these issues with the surgery. Most people and their relatives felt the service support them well to have their health needs met. One relative said, "If my relative was unwell, I would be informed straight away, they sort it out." However, some relatives of people who had complex communication needs, felt the service did not always respond quickly enough to changes in people's health needs or presentation. One relative said, "Monitoring people is their stock response. The staff hadn't noticed my relative had got worse." The concerns were based in the unit with the lowest ratio of nursing staff.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. One relative said, "Staff are caring and they do everything here to help my relative." One person said, "Oh yes, they [staff] do care about me, they are just lovely." During our inspection we observed positive interactions and communications between people and staff. However, we also observed one episode of poor communication, where a care assistant moved someone using a wheelchair from one place to another without communicating with them at all. This was brought to the attention of the unit manager who addressed the issue immediately.

People were supported to practice their religious faith at the service. Various religious groups visited regularly and conducted religious services with people living in the home. In addition, during the inspection we observed religious songs being sung as an activity. People's care plans contained details of their faith and whether they wished to have support to practice it.

Care plans contained details of people's significant relationships and memories. There was a section in people's care plans called, "Personal Life History" which contained details of people's key relationships, memories and how talking about these made them feel. Where these were well completed they contained important information to help staff build relationships with people they supported. For example, one person's history contained details of their liking for jazz music and key achievements their children had made which made them feel proud.

Staff told us how they ensured that people's privacy and dignity was respected, for example, by ensuring that personal care was offered in a subtle way and by ensuring that doors and curtains were closed when people were receiving personal care. Staff told us how they ensured that people were involved in their care. One staff member said, "I ask [person] if they can do it themselves and let them do for themselves what they can."

Care plans told staff to "Respect dignity and privacy" while providing personal care. The instructions relating to how to do this included that the doors and curtains should be closed. This section also included whether people had preferences for the gender of their carer.

People were encouraged to bring personal possessions to the service when they moved in, such as photos and personal touches for their bedrooms. Some people gave us permission to look in their bedrooms and we saw they were personalised with family photos.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us about the referral and assessment process. Following initial enquiries all referrals were managed through the registered manager. The registered manager, or the deputy manager completed initial assessments with people and their families. At our previous inspection other senior staff had been able to complete these assessments, but due to staff turnover the only staff qualified to complete this work were currently the registered manager and the deputy. After the assessment and initial visits to the service had been completed, and people had agreed to the terms of service, people moved in. The provider specified the highest risk care plans, including those for personal care, breathing, moving and handling must be completed within 24 hours. Then the next set of plans must be completed within seven days. The registered manager told us they involved people and their relatives at each stage of the process. However, records did not clearly capture how people and their relatives had been involved in writing their care plans. For example, only some sections of one person's care plan had been signed and a further two contained no signatures of people or their relatives to indicate they had been involved in writing the documents.

Care files contained plans relating to various areas of support including, capacity, medical conditions, communication, personal hygiene, continence care, mobility, falls, tissue viability, weight, appetite and eating, breathing, pain management, sleeping and behaviour. Although some preferences were recorded, there were limited details for staff to follow to ensure that people received personalised care. For example, one person's care plan gave good detail regarding their sleep routine, stating, "[Person] goes and comes out from bed three to four times before [person] settles. [Person] likes to have tea and snacks with night medicines and goes to the toilet three times per night." Details regarding the person's preferences for light levels, pillows and furniture arrangements followed. However, this person's mental health and cognition care plan stated they experienced memory loss, were restless and pacing but contained no strategies for supporting the person to manage this.

Another person, who had recently arrived at the home for a respite visit had complex communication needs. Their relative explained there were specific ways of communicating with them to facilitate their understanding and cooperation with care and treatment. However, the person's communication plan stated they had clear verbal communication. A third person's mental health and cognition care plan stated that they experienced delusions but the only guidance for staff was, "Staff to support and reassure [Person] at all times. Give prescribed medications." This person's care plan indicated they had become more withdrawn. They had previously engaged with activities in the home, but now did not. The care plan stated in relation to activities, "[Person] does not initiate conversation or even enjoy conversation. [Person] does not respond to conversations about activities and this tells me that [person] wishes to be left in peace." There was no record to show that alternative activities or interventions had been sought for this person to try. This meant care plans were not consistently personalised with details that would ensure staff were providing person centred care.

Care plans were reviewed on a monthly basis by staff. Records showed that staff signed to demonstrate they had reviewed care plans each month and this indicated they were current. However, updates in response to events and changes in need were not clear and plans were not consistently updated. For example, one

person had experienced a fall in May 2016. Their moving and handling plan and risk assessment stated, "[Person] falls risk assessment is 24 and he is on a moderate risk of falls. He has supervision one to one." There were no further details regarding what support this one to one supervision was to provide. This person's falls risk assessment stated, "Ensure supervised when mobilising and supported if required." The falls assessment plan had not been amended following the fall.

Another person had recorded in their review in June 2016 that they were not happy with how they were described in their care plan. There was no record of any actions in response to this feedback, and the tone of the care plan was not personalised. For example, it stated, "[Person] to have daily bed bath." And "[Person] needs feeding by staff." One person's relative told us they had requested changes in the care plan. They said, "When I tell the nurses that I want to make changes they are very keen and listen to me and so on, but when I leave I do not know what happens. To be honest, all I know is that everything looks the same and nothing is done." This meant the service was not consistently providing care that was responsive to people's changing needs.

The home's policy was to hold meetings for people who lived in the home four times a year. Records showed three meetings had been held in the last year, the most recent of which was in May 2016. Records showed the meetings were used to discuss food, housekeeping, views on care and activities. The registered manager did not hold meetings for relatives. This was because they found they were not effective at engaging relatives and attendance levels were low. Instead the registered manager held relative's surgeries where relatives could meet with the registered manager on a one to one basis. Records showed the registered manager had met with seven relatives through surgeries in the last year. These meetings had been used to discuss individual concerns about the care received by people living in the home. Relatives we spoke with told us they would like meetings for relatives to be re-started.

The home had a comprehensive complaints policy which specified the timescales for response and how to escalate concerns. Records showed the service had investigated and responded to formal complaints in line with its policy. At our last inspection we made a recommendation regarding the monitoring and resolution of all complaints, including those raised informally. The records of complaints received now included both formal and informal complaints. However, there was no record of any thematic analysis of complaints or application of lessons learnt to ensure that the same issues did not arise again. The registered manager was aware of the themes of complaints and described the actions taken to address them.

The home employed two activities coordinators who led on individual and group activities for people living in the home. Records showed that individual activity profiles had been completed for people and activity coordinators completed a monthly summary of what activities people had participated in. On the day of our inspection one of the activity coordinators was not in work, and the other activity coordinator was being used to cover a gap in the rota. This meant they were unable to provide the activities that had been scheduled.

People and their relatives told us they did not think the activities provided were sufficient. This was particularly the case where people were unable to leave their bedrooms, or where they were living with dementia. A relative said, "There is not much one to one room activities, which because of his condition is quite critical." Another relative said, "There are not enough activities going on as far as I know." People gave us similar feedback, one person said, "Not much activities going on here, I sit all day in my room." Another person said, "They do activities, little ones, but they are not for me as I am bedbound."

Records showed the activities coordinators facilitated one or two group activities each day they worked. The attendance at group activities ranged between two people and 13 people, with most sessions being

attended by seven people. Records showed the same people tended to access group activities repeatedly. At the time of our inspection 79 people lived in the home. This meant, on average, only 10% of people living in the home accessed group activities. During the inspection, we observed a group activity of singing religious songs on the ground floor. This was not the activity that was displayed on the activities board, and people were not asked if this was what they wanted to do before the activity started.

We recommend the service seeks and follows best practice guidance around the provision of activities in care homes, particularly for people who cannot leave their bedrooms and people living with dementia.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post and clear management structure with a deputy manager and unit leads for each floor. Additional management support was provided from the regional manager, the regional development nurse and other specialists from the provider including a dementia specialist. Staff spoke positively about the registered manager, saying, "She is good, she is helpful. Whenever you need her she will always come and talk to you."

Feedback from people and relatives was more mixed. One relative said, "I know who the manager is, there are two and I know them both really well. If I was concerned about anything then I know where to go." A person told us, "I think the manager is doing a good job, I have seen her walking up and down." Other people and relatives told us they did not know who the registered manager was. Two people said, "I don't know who the manager is." A relative told us, "The manager is rarely out on the units and never acknowledges emails." Another relative said, "We don't see the manager in the units. She's in the office with the door shut."

The service held short daily meetings with the registered manager, deputy manager, unit leads and head of housekeeping. We joined this meeting on the first day of our inspection and observed that it was used to feedback on people living in the home, staffing levels, accidents and incidents, complaints and appointments. As it was a hot day on the day of our inspection unit leads were reminded to support people to wear sun cream if they went into the garden and to ensure people stayed hydrated.

The service had a folder which contained records of various health and safety checks and buildings risk assessments. These included fire safety checks and moving and handling equipment checks. Where issues had been identified there were action plans in place to address them. Records of fire drills and practice evacuations had been completed in the home. The guidance notes stated the home should complete a minimum of four evacuation drills in a year. Records showed the home had only completed three drills in the last year. The buildings risk assessment had also identified issues with lighting and security at the entrance to the building. This had also been raised by a relative due to anti-social behaviour outside the home. It was noted that these actions had been carried forward from the previous year's risk assessment. The registered manager told us this was because the work required the cooperation of leaseholders in the neighbouring building owned by the provider. This meant the actions to reduce the risk to relatives and staff arriving and leaving the building late at night had not been completed.

Records showed that staff held regular unit meetings where people's needs and any changes to care were discussed. Records showed these were also used to remind staff of proper recording practices. The service had held staff meetings for senior carers, health care assistants, and nurses in July 2016. Nurses had also had a meeting in February 2016, however, the other groups of staff had not had a meeting recorded since before our last inspection in July 2015. The provider's policy stated that the service should hold quarterly health and safety meetings. Records showed that the most recent health and safety meeting was held in January 2016. After the inspection the provider sent us minutes of a health and safety meeting dated 24 May 2016.

The home completed various audits of care files and medicines records. The deputy manager completed regular spot audits of care files and the unit managers completed monthly audits of medicines administration records on the units. These generated action plans which were agreed and signed off by the registered manager. Although the registered manager told us they also completed spot checks of care plans, this was not supported by the spot checks viewed which had all been completed by other members of staff.

In addition to the checks completed by the deputy manager, regional managers also completed various quality assurance visits and spot checks of care files. Audits completed by the regulation manager in May 2016, by the regional clinical development nurse in August 2016, February 2016, and by regional managers in August 2016, June 2016 and November 2015 identified similar issues on repeated occasions. For example, a lack of detail in care plans, a lack of evidence of family involvement in care planning and reviews, and issues with the physical environment were first identified in November 2015. These issues were identified again in following audits and spot checks which meant despite the action plans being signed off as completed by the registered manager, the actions were not effective as the issues were not resolved.

The audits completed by senior managers were inconsistent with each other. The audit completed in June 2016 stated there was evidence people and their relatives had been involved in reviews and health and safety meeting minutes were viewed. However, the August 2016 audits states, "Residents are not attending six monthly reviews and some are not aware of their care plan." The August report also stated that health and safety meeting minutes were not available.

The audits completed by senior managers had identified issues that were found on inspection. For example, an audit completed in May 2016 identified that the recording of transdermal patches was not being recorded fully. This was identified as still being an issue on inspection. This audit had also identified protocols for the administration of 'as required' medicines had not been completed and were not in place. This audit had an action plan which was to be completed by 27 May 2016. We found these protocols were still not in place during our inspection. This meant the actions taken in response to these audits had not been effective as the issues had not been resolved.

The recurrence of the same issues in spot checks and management audits was discussed with the registered manager. The registered manager said this was because of the high turnover of nursing staff at the service. They said, "The new staff means we have to start again, and continue picking the same thing. We have had eight new nurses since November [2015]." When asked if care plan documentation was covered in induction, the registered manager said, "They [nurses] are from overseas, care plan writing is new to them. The language and expression is different. We are supporting them to learn a lot at the same time. From November to now, I can see improvement." This was not supported by the inspector observations regarding the quality of documentation, or by the most recent audits completed by the provider's regional management team.

Incident reports reviewed showed that the home was not analysing incidents for themes and the management actions plans were insufficient to demonstrate any understanding of the cause of incidents and how to prevent future incidents. The incident reports for July and August 2016 were reviewed. These included an incident where one service user hit another service user. The cause of the incident was recorded as, "Sitting in his seat." And the long term actions were recorded as, "Monitor and supervise residents to prevent recurrence of such incidents." An incident where someone was found on the floor was described as being caused by, "Exercising his independence." And the long term actions were, "[Person] must be constantly monitored. To be with other residents in the two lounges most of the time." The long term actions for a further six incidents were that staff were to "Monitor and observe" people. There was no analysis of the causes and triggers to incidents where people were physically violent to others. These

incident reports and actions were all completed by the same member of staff and signed off by the registered manager. The member of staff told us they had not been trained in incident investigation and response. Their induction record was viewed, which showed although incidents and accidents had been discussed on multiple occasions, investigations had not been covered. The registered manager told us they had explained the investigation process to the member of staff. However, this had not been effective as investigations and long term actions were insufficient to demonstrate the risks to people and the service had been appropriately managed.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not consistently record consent to care and treatment in line with legislation and guidance. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments lacked the detail required to effectively mitigate risks. Medicines were not consistently managed in a safe way. Regulation 12 (1) (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The actions taken to improve the quality of the service had not been effective. The service had not consistently identified and addressed risks to service users. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The home did not deploy sufficient staff to ensure people's needs were met. Regulation 18 (1)