Bupa Care Homes (CFHCare) Limited

Anglesea Heights Nursing Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 05 and 19 November 2015. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not

Summary of findings

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

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

The last comprehensive inspection was 29, 30 October and 6 November 2014. The overall rating was Requires Improvement. The one domain of 'Effective' was rated as Inadequate. We found two breaches of legal requirements at the last inspection. At this inspection we found some, but not enough improvements have been made to meet the relevant requirements.

Anglesea Heights Nursing Home is a care home with 120 beds divided into four separate buildings with 30 beds in each building: Alexander House, Gyppswyck House, Christchurch House and Bourne House. Each house provides nursing care. There is a registered manager in place they had been appointed in June 2015 and had recently become registered with us. A registered manager is a person who has registered with the Care Quality Commission [CQC]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.

A local manager with a good track record for managing services well was appointed to bring this service up to standard. We found that they had a good grasp of the issues needing to change and were working well with other outside agencies within health and social care. However, they were not appropriately supported by BUPA to bring about change. The manager has resigned from their post with other managers and key positions within the home also being vacant, suspended or resigning. This has led to concerns being expressed by the local authority and CQC. The main concerns focus mainly on Bourne House.

The manager had been recruiting staff to various positions within the service, including nurses, carers and housekeeping and catering. However, the high usage of agency still impacts upon the experience of people using this service. We also found that though well recruited staff did not always have the training to fulfil their roles nor the supervision and guidance to meet people's needs.

People, dependant on where they lived within the service, experienced differing care and support. Some experiences were positive and others were not. Access to health care was not consistent and people were placed at risk of not having healthcare provided. Medicines management was not robust and some people were at risk. There was a high number of covert and crushed medicines being used and this was not always with the appropriate consent. Consent to care was for some people not obtained and people were at risk of having their liberty and rights infringed on a day to day basis because some people were placed in box chairs, bedroom doors routinely locked to prevent people from using their rooms or people were isolated in their rooms with no staff supporting them who spoke their language. Some people had good care with risk assessments in place to minimise harm, whereas other people either did not have risk assessments in place or staff were not aware and following plans in place. The premises were not routinely kept clean and hygienic and therefore people were laced at risk through cross infection.

Managers in BUPA external to the home were visiting and were aware of a limited number of issues within this service, but had not grasped the impact and were not taking action to support and change matters within this service. Some of the concerns we have found are repeat matters relating back to our inspection last October 2014 and February 2013.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not always safe

Sufficient staff were deployed to meet people's needs, but these were made up with a high use of agency, therefore knowledgeable and consistent care could not be assured. Staff were recruited effectively.

Assessments for risk were not always accurate and actions to reduce risk to people ensured.

Systems for management of medicines was not robust and did not ensure risk to people was always reduced.

The provider had appropriate systems to prevent risk of abuse, but these were not always followed by staff.

Appropriate action had no always been taken to ensure a hygienic home and reduce risk of cross-infection.

Is the service effective?

Inadequate

The service was not always effective.

Where people lacked capacity, effective processes did not take place to ensure they were not deprived of their liberties. Lawful consent to care and treatment was not always in place.

Timely and effective access to health professionals was not consistently available to people.

The provider's systems did not ensure people were provided with a nutritious diet that met their needs.

Staff lacked knowledge and understanding despite training being provided for staff this was not checked for competence or effectiveness.

Is the service caring?

Requires improvement

The service was inconsistently caring. Some people experienced kind compassionate care, but others did not dependant on where they lived.

Visitors could come into the home as and when people wanted them to.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care and treatment needs were not always met, including people who had dementia care needs.

Summary of findings

Social engagement was supported by the provision of an effective programme of activities. But ordinary opportunities for people living with dementia were missed.

Systems for consultation with people were in place and their concerns were documented and acted upon.

Is the service well-led?

Inadequate

The service was not always well-led.

The provider's systems for audit had not ensured that identified actions from the last inspection had been addressed. The manager was not effectively inducted.

Culture within the home had begun to be more open and transparent, but would not be sustained as the driving force of the new manager had resigned.

Pockets of closed practice remained with staff coping day to day.

Anglesea Heights Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 05 and 19 November 2015 and was unannounced.

The membership of the inspection team consisted of three Inspectors and included 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. Their area of expertise was older people and conducting interviews.

We gathered and reviewed information before the inspection. This included information from the local authority on safeguarding's received, 'Tell us your experience' information gathered through our website, from people who had contact with the service and statutory notifications. These are significant events that the manager must legally notify us about.

During our inspection we observed how the staff interacted with people who used the service, including during lunch. Some people were unable to speak with us directly because of communication needs relating to dementia. We used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The methods that were used during inspection included, talking to six people using the service, 13 relatives and friends or other visitors, interviewing 14 staff, pathway tracking seven people, observation of lunch time in each of the four houses and reviews of records. These records included training records, five staff recruitment files, medicine records, policies, procedures and audits of quality monitoring and other records associated with the running of a care home.

Inadequate

Is the service safe?

Our findings

At a previous inspection in February 2013 we had concerns that there were not enough staff on duty. At our last inspection in October 2014 we were concerned that staffing numbers needed to be consistent and sustained. At this inspection we remain concerned about the long term impact of high staff vacancies. People were concerned about the staffing levels and the repeated use of agency staff. One relative in Christchurch House told us, there "Has not been enough staff but the new manager she has increased levels drastically but now staffing levels are good and staff are very friendly to relatives and to the residents". Whereas another relative from Bourne House said, "It is not too bad but they need more staff so that [my relative] gets their needs taken care of – it is worse at weekends". They went on to give an example of the impact of lack of staff and said, "Yesterday at 4pm [my relative] had only had 350mls of liquid and we spoke to [the person in charge of the house]. It is hit and miss with liquids and depends on shifts, today is a good shift and look here now at 1510mls. But if you say anything to them they just add it on or say that they had forgotten to write it down". A different relative gave us an example of impact upon people. They said "Repositioning says hourly on the chart and today is a good day but sometimes it is every 2 hours or longer and depends how busy and how many and which staff are on. They need more staff". A person using the service told us, "I think they're overworked, they don't always have time, but it's hard to make time".

A relative said, "They use agency staff but it would be better to have permanent staff as they would have rapport with the residents" They went on to tell us why this would make a difference and told us, "Another residents daughter came to see me as she was horrified to find her father in a soaked bed but is its normal occurrence. It depends on who [staff] is on. Last time my Dad's [bed] was soaked was a few weeks ago".

There had been a high turnover of staff within the last 12 months. The service continued to experience problems with retaining staff and covering staff absence. There was a high use of agency staff including agency nursing staff. On Bourne the two lead nurses were currently not in post and had to be covered by agency staff. On the day of our inspection we found two agency nurses working with each other. This meant that there was a higher risk of nursing staff not knowing the needs of the people and therefore unable to provide individualised care in line with care plans agreed. During the lunchtime observation on Bourne House two agency staff did not know the name of one person they were supporting with their meal. They also told us they regularly worked at the service.

The manager had recruited into 700 hours of vacant posts. However, there was a further 216 nursing staff hours vacant and 190 health care assistant hours vacant. The manager had recently organised a rolling four week rota which they told us would enable a more organised system for the allocation of staff and planning for staff annual leave absence. This was due to be implemented in January 2016. A new dependency tool had been developed by the manager to be used alongside the organisations current tool. This enabled a more concise recognition of staffing needs to support people who had been identified as at risk and those who required additional staff to enable them to be supported with safe moving and handling.

Two people as a result of safeguarding concerns had a protection plan that stated they now required one to one support. This further increased the numbers of staffing hours required to support the safety and welfare needs of people. These hours were funded by the local safeguarding authority and supplied by the service.

We observed staffing levels. On Gyppswyk House we saw some meaningful interactions that showed staff had the skill to support people. For example, a carer was supporting a person at breakfast. The person expressed distressed behaviour and the carer showed good skills by chatting, smiling, diverting the person and encouraging her to eat. A different person with a history of falls was being watched by staff and immediately they started to get up a member of staff was by their side, asking what they wants to do and giving choices but allowing the person to walk. Breakfast was still concluding at 11am on Gyppswyk House. We asked the person in charge about this and they told us, "Yes finishing breakfast late does impact on lunch – more staff would mean we could finish earlier". During the lunchtime period on Bourne staff appeared rushed and task focused and did not work at a pace that suited the needs of people living with dementia. For example we saw one person who became distressed by the presence of staff standing too close to them and lashed out. Staff did not take the time to reduce their anxiety but instead walked away. The atmosphere on Bourne was chaotic and loud.

Inadequate

Is the service safe?

We saw people distressed, walking and pacing around. One person was trying all the outside doors without any staff intervention or support. The second day we visited was calmer.

Nurses and staff allocated as the lead for each house had little time to spend formulating and reviewing care plans as well as time to supervise and competency assess clinical staff. This was because they worked providing hands on care and administered people's medicines on a daily basis with no allocated days to catch up on their admin and ensure appropriate supervision and support of staff. We saw that these lead staff worked very hard with no let up between tasks.

This was a breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Risk to people's safety had been assessed, but mitigating actions were not always in place. We asked peoples relatives if people were protected through risk assessments to keep them safe.

A relative on Gyppswyk House told us, "He is safe here, I am here almost every day at different times, and I see how he is cared for, they are attentive to him for instance if he has fallen to one side of his chair they will make him more comfortable". A relative in Christchurch House said, "Hoisting – she cannot communicate but I observe and it is good". We observed on Gyppswyk House that when a person got up from their chair a member of staff called across to another staff member who walked with the person hand in hand and supported them to the toilet. On Bourne House we saw spills next to tea trolley not mopped up and in the afternoon someone had wet the floor on the back corridor over about 10 metres and one person who had a history of falls was walking through this area. This same person was continually walking around, on their own for a while and then later linked arms with another resident.

We looked at this individuals care plan and found a falls risk assessment in place with a care plan. Instruction to staff was to monitor this person whereabouts. We did not see staff working together to monitor this person. It went on to say that they should use a pram for support and not other people because if they fell they would both potentially injury themselves. We were told that the pram had broken over a month ago and had not been replaced.

Finally strategies were to keep the person occupied, such as wiping tables, – none of which we saw happening. In other Houses we saw up to date risk assessments in place and staff supporting people appropriately. Many people required two staff to assist with supporting them to safely mobilise. In Bourne House one person was seen to be pushed in a wheelchair with no footplates on and ill-fitting slippers. When staff were asked why they did not have foot plates on they told us that this person did not like them. There was no risk assessment to explain the reasons for this and guidance for staff in mobilising safely within their care plan. We concluded that though plans were sometimes in place these were not routinely followed on Bourne House.

This was a breach of the Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Guidance was available to staff to inform them of how to manage risks. For example, where two people had been identified as at risk as a result of safeguarding referrals, protection plans had been put in place. Where staff did not comply with these protection plans action had been taken by the manager to performance manage these staff and reinforce where action was needed to safeguard people.

We asked a relative if they thought people were safeguarded from harm and potential abuse. They said, "I think she is safe and they cope quite well when she has an off day".

The manager had taken action to raise safeguarding alerts to the relevant safeguarding authorities. Where these authorities had requested internal management investigations these had been actioned and outcomes with action plans evidenced. There was a high number of safeguarding referrals recently and the manager had developed a tracker to show where each referral was in terms of investigation and outcome. There were appropriate policies and procedures in place and staff had been trained in safeguarding adults from abuse. However, we remain concerned as recent referrals suggest that matters have gone unreported and actioned in the past and for some time. The culture with staff had not been encouraging to raise concerns. We have concerns that people may be being routinely deprived of their freedom by being placed in chairs from which they cannot stand.

Inadequate

Is the service safe?

Bedroom doors are routinely locked to restrict people's movement. One person was being discriminated against due to their lack of English speaking and was not provided with stimulation using their own language.

This was a breach of the Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Five staff files reviewed showed that effective recruitment procedures were in place to ensure staff were suitable to work with vulnerable people. All relevant pre-employment checks had been carried out. These included obtaining two references one from the most recent employer, copies of interview questions and responses made, Identity and criminal records were checked. However, where staff had provided limited information with regards to previous employment it was not evident that this had been explored as to the reasons they left that employment. On balance staff recruitment was safe.

People's medicines were not consistently managed safely. We saw some good interactions with nurses around the service when giving medicines. Nurses were seen to gain consent from people prior to giving them medicines. We heard one nurse say, "Hi how are you? Are you alright? Have you got pain anywhere? I have got your medicine here." We saw that medicine was ordered on time and medication administration records showed no gaps. In Bourn House there were two agency nurses giving medicines. They showed us that each person had a photograph to identify them and told us they asked people their names and if unsure checked with care staff that they had the correct person. Medicines were stored at the correct temperature, but on Bourne house controlled drugs were not safely stored because these should be double locked within a medicine cabinet. We saw these were stored within a medicine cabinet in an unlocked staff room. The agency nurses told us that the morning medicine round took two nurses up to two hours to complete due to the complex nature of the people they supported. The agency nurses had a list of people who had their medicines either crushed or given covertly. Covertly meaning without the person knowing they were taking them. There were eight people listed as having medicine given in this way. This was a large number than ordinarily seen. We tracked one of these people and saw that there was not a best interest decision made to give covert medicine. For another person there was a note from a GP who stated that medicine for this person could be crushed. But this was some time ago and the person had changed GP surgery and the note did not say which medicine. Medicine prescribed can also change over time. One of the medicines was digoxin and this can be obtained in a liquid form. We looked at the same persons as and when required medicines (PRN – 'pro re nata', as needed). They were regularly being given antianxiety drugs. But we also saw that they were not receiving their regular prescribed pain killer as staff thought this was PRN and had not given it in that circumstance recently either. We concluded that medicine management was not as robust as it should have been to protect people.

This was a breach of the Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

We had received concerns about the cleanliness of the service. One relative told us, "Recently the room has been cleaner, say over the last month. They now got two cleaners". A different relative said, the "New manager has been sending lots of cleaners around". Staff we spoke to on inspection also raised concerns about cleanliness and lack of hand soap. In Bourne house a bathroom was not clean. The shower chair had faeces on it. There was no toilet roll available for people to use. The hand rail was rusty and the shower drain had no cover, exposing the drainage system. We fed this back to the manager who had already conducted an audit of bathrooms and was aware of the issues needing to be addressed. We also fed back our concerns that many areas were in need of redecoration and the gardens were not as smart as they once were. The manager said there had previously only been one domestic staff member allocated to each House. They had increased this to two cleaning staff per house and were currently still recruiting into these posts. A gardener was being recruited and a systematic redecoration of the environment was under way.

This was a breach of the Regulations 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Inadequate

Is the service effective?

Our findings

At our last inspection in October 2014 we found staff training and development was not sufficient in some areas to show that people's healthcare conditions were fully understood by staff so their needs were recognised and met consistently. At this inspection we found people were not always supported to maintain good health. We found that people were not routinely added to the visiting dentist list to have a check-up. This had resulted in one person being the subject of a safeguarding referral. This person did not speak English and therefore had not been able to communicate to staff that they had a toothache. A different person was not referred to a chiropodist as they had been asked to provide funds for a private practitioner. This showed us that nursing staff did not understand how and in what circumstances people could access free NHS healthcare within this country. This person's feet were in such neglect that they too were referred to safeguarding. One relative told us. "They look after [my relative] quite well and they ring and say the doctor has been and he feels [my relative] is doing alright". This person went on to tell us about their concerns relating to the management of their relatives diabetes. We brought this to the attention of the managers who contacted the GP and updated the care plan and consulted this relative. This had previously been raised by the relative but had not been addressed until now. In addition the managers were arranging meetings with the GP to review all healthcare needs of people so that they had the most up to date relevant information to guide and inform care plans and staff.

This was a breach of the Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

The manager had a good understanding of both the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) and when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions. 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 are called the Deprivation of Liberty Safeguards (DoLS). The manager had completed a number of DoLs referrals to the local authority in accordance with new guidance. We found that consent to care and treatment was not always sought in line with legislation, guidance and the services own policies and procedures. All staff were said to have completed training on the MCA and the DoLS as this was part of the induction training for all staff. However we found that staff did not understand of fully practice these principles. The trainer believed this was because the staff do not have their knowledge and competency checked once they return from training and the lack of ongoing supervision of practice did not pick this up.

At the last inspection in October 2014 we found that staff had not recognised the potential impacts of restricting people's movement or explored alternatives to see if there was a more suitable and less restrictive approach, nor had people been formally assessed. This time we found that on observation staff did tend to offer choice and respected decisions made, but where people lacked capacity and important decisions had to be made there was no understanding from staff. Records seen did not give us confidence that best interest decisions had been made by involving appropriate professionals and people who had lasting power of attorney. We found several different examples and these included; people being placed in 'box chairs' so that they were unable to stand when they wished. These were chairs that were tilted backwards to prevent a frail person from standing up independently. One relative told us they had not been consulted about this even though records said they had been in agreement. In another record for someone in a 'box chair' there was no best interest decision recorded. Just a record stating '[Name] likes to be in the chair'. We believe staff wanted to prevent the person from falling over. In other cases we found that consent had been given to receive medical treatment and no best interest decision was recorded. The example there were people receiving the flu vaccination. Throughout Bourne House peoples bedroom doors were

locked to prevent them from going into their own room. A large bunch of keys was located in the office that staff accessed throughout the two days of our inspection. We found no reference in any plan to this decision and why it was made for the majority of people living in Bourne House. All the above concerns accumulating with concerns on medicines being administered covertly and crushed, we concluded that there was a disconnect between staff training and the practical application of MCA and therefore people's rights were infringed on a daily basis.

This was a breach of the Regulations 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

At the last inspection in October 2014 we reported that support for staff learning and development was inconsistent. On this inspection we found there was a system in place to provide newly appointed staff with induction training. This covered five days and included time observing, getting to know the people and staff they would be with once inducted. One new person told us after induction that they, "Felt confident and competent because there was plenty of people to ask questions of". Another new person told us, "I felt nervous but competent and I was put with a more experienced second person to support me". We wanted to know if staff had the training in place to enable them to support people living with dementia because this was the majority of people using this service. Records showed that there were two courses offered. 89% of care staff had completed the 'Care of a Person with Dementia' course, that is an introduction. However only 63% had completed 'Person First Dementia Second' training. The manager explained that they had put plans in place starting to cascade this training in January 2016.

We wanted to know if nurses had the up to date skills and courses completed to meet the needs of older people who use this service. We found that only one nurse in this large service had up to date skills to set up and use a syringe driver [This is a direct way to deliver pain relief at the end of a person's life] Only two nurses had completed training in catheterisation of people. Only four nurses had successfully completed venepuncture training [collection of blood from a vein]. The main courses that nurses had attended related to pressure ulcers, medicine administration and nutrition. Some of these had been completed four years ago. Nurses were not provided with the appropriate supervision and skill set to deliver the nursing care people at this service needed. There was not an effective way to see what training nurses had, needed or was planned based upon the people's nursing needs using the service.

The in-house trainer who previously tracked, planned and provided face to face training across the service for care staff had recently been reassigned and now worked as an area trainer now providing training across several of the provider's services. They told us they now only provided training and were no longer responsible for identifying staff who required training including refresher training. It was no longer clear as to who was responsible for bridging the gap and how the tracking of those staff who required updated training and in need of competency assessment would be organised. We were concerned that our findings of lack of staff understanding on the MCA and DoLS had not been identified and addressed. The long term absence of the trainer had also resulted in a back log of training. In Bourne House we could not find any system of staff supervision. In Gyppswyk we were told that due to staffing numbers supervision had not taken place. Staff said managers were approachable and they could ask questions if needed. Staff team meetings had begun to happen. In a team meeting between our two inspection days managers leant there was a practice of sharing underwear known as 'net pants' to secure continence aids. They were addressing this dignity issue with staff. We concluded that staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and support to people safely and to an appropriate standard.

This was an ongoing breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People had different experiences of eating and drinking and able to maintain a balanced nutritious diet depending upon which house they lived within Anglesea Heights. People on Gyppswyck were offered choice of breakfast. On person said, "The scrambled eggs were quite nice, I could have had bacon". A different person said, "I had the scrambled eggs and bacon, it was nice" This person had a plate guard to support with independence. We saw that breakfast was a pleasurable experience with staff consistently chatting to people and not hurrying them and giving encouragement. On Christchurch over lunch we observed a calm atmosphere with people being individually supported where needed. One person told us,

Inadequate

Is the service effective?

"I had chicken they cut it up for me – it was very nice". In Alexander House most people in the dining room were independent and there were eight people supported by staff to eat in their rooms. People were generally offered choices of second helpings and puddings. Staff did not consistently offer choice of drinks and flavours of yogurt. We saw staff asking for consent before supporting people with putting on aprons and cutting up food. People told us they liked the food offered and vegetarian diets were suitably catered for.

The mealtime observation on Bourne House showed that there were plenty of staff available. However, staff were busy, rushed and task focused with very little positive interaction with people. Some people were left waiting whilst others were supported with eating their meal. This impacted on those people waiting and we observed some distressed behaviour when people waiting saw other's meals and indicated that they were hungry and could not understand why they were left waiting.

One person who ate all of their meal asked for more to eat. The member of staff promptly brought them another dinner to eat. However, other people did not always receive the encouragement they needed to eat and drink well. For example, one person was left with their meal in front of them. They only ate one spoonful and sat with their meal for 20 minutes before staff came and took their main meal away without any offer to support them to eat any more. It was only when they were given their pudding that staff sat with them and supported them to eat. Another person again who barely ate any of their main meal, staff took their plate away without any offer to support them to eat any more.

We observed another person where staff were at eye level with the person, but said very little to them throughout them being supported to eat their meal. The person was at times rushed to eat another spoonful before they had finished their last.

Another person who was observed to be restless throughout the lunch time period was eventually supported to sit in an armchair whilst two staff attempted to support them to eat their meal. We had concerns that this person was being restrained as a table was placed directly in front of them which prevented them from getting up and one member of staff held their hand to distract them whilst the other supported them to eat.

We looked at this person's care planning in relation to their eating and drinking as they were pale and looked very slight in build. We found that they had been referred to a dietician and their weight was being monitored, but the interventions in place were not consistently applied and therefore the person had not gained any significant weight. Records were contradictory. The Professional Visit/Referral Log records that dietician phoned. A member of staff updated them that this person's food intake continues to be very poor, but this was not reflected in her daily record which states for the most part that she was eating and drinking well. However the food log for this person regularly recorded half potions of food eaten and on some days only 700mls of fluid drunk.

This was a breach of the Regulations 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Requires improvement

Is the service caring?

Our findings

At our inspections in February 2013 and October 2014 we had concerns about dignity being inconsistently respected during mealtimes. At this inspection we found that depending where you resided within the service and any given day people's experiences did vary. On day one we had concerns about the lunchtime service for people in Bourne House. The experience for some was stressful and task focused. The environment was busy, loud and at times chaotic. On day two following our feedback, the chef led meal service and the experience was more positive and more organised. Staff were more able to manage the busy lunchtime where several people needed support to eat. We fed back to the manager where further improvements could be gained.

We consistently found that people were given privacy. Peoples door were closed during personal care. A relative said, "Staff are pretty good and they do knock if we have shut the door – some staff are fantastic and look after him well, – [The nurse] does their best for the family and always listens to us". Another relative said, "They ring me if there is something they need to tell me and staff always have the time for me and bring me up to date". However another relative experienced something different and said, "Sometimes you hear afterwards that she has had a bad day, I come in 5 days a week and it could be 4 or 5 days after it has happened. Staff could say when you walk in 'she is having a good day' I am not getting much feedback – it could be better". We found that relatives were inconsistently involved in their relatives care delivery. We found a lack of consultation in some areas and in others inappropriate health treatment decisions had rested with relatives.

Relatives had mixed views about the caring qualities of the service. One person was clear and said, "It is pretty good here and I can call in anytime and they never know when I am coming and I know he is looked after to the best of their ability – some of the staff are very special people".

A different relative from a different house said. "I am informed about everything, he is having a bit of a problem with his dentures and the Nurse has told me she is making arrangements to have the Dentist, he has got nasty patches on his leg and toe, the first sign of anything I am told – staff are brilliant and they really care and are so good at their job". In Gyppswck House we observed caring and kindness.

One person was anxious about personal care being given. The door was closed, but we overheard two staff talking kindly and encouraging the person. They went on to say, "Do you want a cup of tea, how about some breakfast?" We also saw five staff here assisting with breakfast allowing people to go at their pace and chatting along about their families. We heard conversations from staff [including housekeepers] empathising with peoples ailments. This showed concern and kindness for the individual's circumstances. On another house a staff member said, "I am just back from taking [named person] to hospital – it is not very nice to go on your own". This was the experience of some person but was not the same experience for everyone. There was inconsistent care afforded to people at the service. One person said, "Some of the nurses are a bit austere, they can be distant and don't talk to me as they are too busy doing medical things. You don't get the emotional/psychological support. If they had more time to listen to people's problems it would be better". One person who did not speak English was isolated in their room due to their behaviour. This person had nothing to occupy them save for a radio that was set to English speaking. A different person using the service told us, "People let me be independent. My real problem is having to put up with the noise". As an inspection team we found the noise level on Bourne House difficult to tolerate at that level throughout the whole day.

We observed staff involve people in their care and support offering them choice with day to day aspects of their care. Choice was given about clothing, support for the toilet and where to be and eat. One member of staff was overheard whilst supporting someone to dress asking, "Do you need a belt?" A different staff member asked, "Do you want to go to your room, I could bring your coffee?" Options were given and supported to happen. One person using the service said to a member of staff, "You gonna help me? You I trust". A relative told us about how they include people in their care, "Hoisting they are so careful, they talk to him all the time and they tell the residents what they are going to do, all the way through and explain what they are going to do". We saw minutes from a relatives meeting held on Christchurch House in October 2015 and was told of a meeting on Gyppswck House [not minuted]. This showed us that there were mechanisms to listen to relatives and

Requires improvement

Is the service caring?

their feedback acted upon. This included matters such as lighting being changed due to negative feedback, assurances that food was hot when served, recruitment progress and activities planned.

Requires improvement

Is the service responsive?

Our findings

The manager has instigated some new systems to make the service people received more responsive to people's needs. This included recently re-instated service reviews. We saw copies of these meetings where relatives and people receiving care had been provided with the opportunity to review their care plan and express their views about the quality of the service provided. The manager had also implemented weekly House meetings with the manager for each house and the clinical lead. This will go on to provide an opportunity to assess the needs of each person and discuss planning for improvement of the environment and staffing needs. In addition the manager had implemented a new system for communicating information from one shift to another had been implemented with a handover record sheet now in use. We saw this handover sheet in action. It was of benefit where there was a high use of agency but it contained a huge amount of information with several codes and was going to be reviewed further. Though the manager had started to implement changes these were relatively new. We found that people did have care plans in place that had dates of recent review in them, but care staff told us that they were disconnected from the care planning process and did not always read these large documents. We found that some of the writing was illegible and the terminology was sometimes complex nursing descriptions. The care planning process was floored for some people and unreliable due to the inconsistent recording of how to make decisions when people lacked capacity. Many people at this service may have lacked capacity due to living with dementia and therefore this aspect should have been thoroughly thought through and meticulously recorded in how care was planned and delivered. This was not the experience for everyone at the service. Indeed one person told us, "I get up at 7.30 and go to bed at 9ish – it is the times I want. It is up to you if you want to stay in the lounge or stay in your room". If people had capacity their experience may have been positive but we lacked confidence due to staffs misinterpretation of bigger decision making and its recording within care plans.

We observed different activities happening throughout our inspection. These included art and craft sessions, hand massages, the activities person kneeling by the side of a person and showing them a magazine. One relative said, "Staff are all very nice. [My relative] has had her hair and nails done and they do ask for her consent". Notice boards showed each day the activity on offer. We saw a trip to Felixstowe was advertised. A member of staff told us, "On Sunday I am taking [named person] across to the Remembrance service in the park. It is something he likes to do". Plans were also being made to visit the town and see the Christmas lights and for clothes shopping. A relative described activities to us, "They [staff] sit and give them great big jig saws and help them, they also do colouring, a Velcro game and wooden table skittles". A relative in Alexander House spoke of a regular poem and book club [Christchurch house] they ran where 10 – 12 people attended. We saw some missed opportunities for people to be involved with the day to day household jobs such as wiping tables and folding napkins. People with dementia could have been engaged more in ordinary tasks and this was not routinely promoted within all the houses.

Most people told us that they could raise concerns and felt that they were listened to. There were formal systems in place for recording and responding to concerns. One person described how they expressed concern about a resident's aggressive behaviour that they witnessed and told us, "I was not fobbed off at all". A different person told us, "Three weeks ago at a residents meeting I complained about the state of the floors. There has been an improvement. They were sticky but now they have two cleaners whereas there was one". A relative said they knew of problems with laundry and told us, "Laundry they are working on – it is an issue". They went on to tell us things that had improved because of being raised. "There have been improvements, they have painted and the flooring here in Bourne House is reasonably new". Another person said, "No complaints here except about the taking away of tablets for her diabetes and doing it by food". We fed this back to the manager and they resolved this matter. Matters that were raised were dealt with.

Inadequate

Is the service well-led?

Our findings

At the last inspection in October 2014 we had concerns about the quality monitoring of this service because views and experiences of people were not listened to and acted upon. In addition we reported that the culture was not open and inclusive and the communication between staff and the last manager was poor. At this inspection all staff were positive about the culture of the service since the recruitment of the new manager. Staff were observed to confidently contact the manager throughout the day of our inspection. Staff said the communication had improved and were positive about the changes taking place. One staff member gave a good example of how the manager quickly responded and resolved an issue when pagers were not operating in the service. Relatives were consistently supportive of the new manager. One said, "I think it is more efficient with this manager and she seems to have her finger on the pulse more". Another relative said, "The manager is new but from what I can see she is improving things, - there are now more carers and kitchen staff, and we had a relatives meeting".

The manager was stressed. When the manager was appointed in June 2015 no management induction was conducted as promised by the provider. Also there was no mentoring from other homes manager's as also promised and only a carers induction was received. A BUPA manager who was originally allocated to support this new manager as part of her induction went sick within the first week of employment and subsequently left. The manager told us they did not see anyone from BUPA for her first six weeks she was in post. The manager was not adequately supported by the provider to understand and manage the role for which she had been employed. We were given vital examples of impact of not having the correct induction. The manager was not aware of the provider's staff dependency tool to formulate staffing levels within each house until this had been shown to her the day before our inspection by another manager. Also the manager had only just been told about the provider's monthly manager's reporting tool. The most recent one was compiled by the clinical lead. This contained limited information and did not drill down into identifying the individuals with pressure ulcers, those at risk of malnutrition and the House they lived on. This did not support the manager in identifying actions and planning for improvement. We could not be sure how this would be analysed by the provider and how useful it was in determining trends given the limited information requested within the provider's tool and the large scale and diversity of this service.

The manager stated she has felt bullied by her direct line management. We saw evidence of emails received by the manager that supported the focus of the provider on non-use of agency staff and filling beds. This had little recognition and regard of the time and support required to get this service up to standard. The manager felt isolated to drive improvement alone. And told us there not enough resource available to support her. There was currently no deputy manager in post. One member of staff with a degree in psychology and a degree in dementia care mapping was supporting the manager with planning and driving through improvement. This had been organised by the manager herself. However, senior managers had decided that this person should go back on to the rota to provide hands on care to reduce agency staff usage. This meant that the manager was left with limited support, trying to run a large service day to day, recruit staff, plan and prioritise action to meet the improvement plan put together by previous management alone and positively mobilise the work force whilst coping with sever staffing shortages. During our inspection days the manager resigned. We also found out that a number of other key staff in management and training had or planned to resign. This coupled with the lack of nurses employed in Bourne House led us to have serious concerns about the management structure in this service particularly over the Christmas period.

This was an ongoing breach of the Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

The current manager had developed good working relationships with other professionals in health and social care. This included the local safeguarding team. The manager had uncovered a number of issues and had reported these appropriately for the local authority to investigate and they had confidence in the new manager and the open culture they were developing. The high number of incidents was a reflection on the changes that the manager was attempting to bring about in learning from investigations to stop repeat events.

Seven complaints had been received within the last 12 months. These were a variety of concerns which included

Is the service well-led?

concerns regarding the attitude of staff, missing laundry and a lack of staff. We found that all were responded to as evidenced from an audit trail of letters to complainants. The manager told us that relatives and residents meetings had been held on each house. The manager had also written to each relative to introduce herself to people and invited them to be involved in the running of the service and their relatives care. Staff had received news letters that kept them up to date with developments and asked staff for ideas and involvement with the service. Team meetings had begun to happen on houses. The new manager was more visible to people and was motivating the staff group.

The manager had a good grasp of issues within the service. They told us that the nursing staff put in charge of each house were not skilled managers. Some had limited English, both understanding and spoken. Also they had very limited time to do anything other than hands on care. We corroborated this from our observations and findings at inspection. The nurses in charge did not have the capacity to performance manage staff which fell to the registered manager who also did not have the capacity given the large scale service. A member of care staff told us, "I would like to have more support. If I had an issue I would feel confident to bring it up. I would go upstairs and talk to the manager, she is very good". Each house was a separate identity with varying standards across and within the registered location. We identified Bourne House in particular as having systemic problems.

We reviewed the manager weekly reports sent to the provider, which included information in relation to; occupancy levels, staff vacancies, admissions, deaths, discharges and agency staff usage. Other audits and quality checks included an observation of the lunchtime meal experience in Bourne House on 28 October 2015. This found similar experiences to those we wrote about in our last two inspection reports. Therefore nothing intrinsically had altered for people with regards mealtime since our last inspection.

The provider carried out audit visits to the service. Two audits had been carried out by the quality lead since the new manager came into post at the end of June. The last quality and safety audit dated 23 October 2015 reviewed was in parts illegible. It was not clear what areas of the service they looked at or what care plans they reviewed. There was no clear action plan with timescales attached. However it did find some of the issues we have highlighted such as soiled toilets, and the controlled drug cabinet security highlighted. However many of the issues we have highlighted in the care and welfare of people were not found. The methodology used was not in depth and corroborative. This highlights again a disconnect in the support and management of this large nursing home by BUPA beyond the registered manager.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was insufficient skilled and experienced staff on duty.** **Staff were not appropriately supported, trained and had access to supervision and professional development to carry out their duties.**

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 were not consistently in place and followed to minimise risk where possible.** **Medicine management was not robust to protect people from potential harm.** **People were not supported to maintain good health with access to healthcare in a timely way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises and equipment were not always clean.**

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 **Lawful consent to care and treatment was not always in place.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of people were not consistently met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not protected from abuse and improper treatment.**

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 **There was a lack of sustained systems in place to assess, monitor and improve the quality of this service.**