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Quinta Nursing Home

Inspection report

Quinta Nursing Home
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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

We carried out an unannounced comprehensive inspection of this service on 14 and 15 April 2015 2015. Breaches of legal requirements were found in relation to staffing and records. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements. The provider informed us the final date by which they would have fully completed their action plan to ensure they met regulatory requirements was 18 October 2015.

In November 2015 the Care Quality Commission received information of concern about the effectiveness of infection control processes at the service. We undertook an unannounced comprehensive inspection of the service on 7, 8 and 9 December 2015. As part of the inspection we included infection control and checked to see if the provider had completed their action plan in relation to the previously identified breaches of regulatory requirements.

Summary of findings

Quinta Nursing Home is registered to provide nursing care for up to 41 older people some of whom are living with dementia. At the time of the inspection there were 37 people living at the service.

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.

The service did not have a registered manager in post as required for this location; the provider had informed us on 7 September 2015 that the service was being run by the deputy manager. The provider intended that the deputy manager would become the manager of the location and submit an application to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We have asked the provider to ensure the previous registered manager submits an application to de-register as the registered manager of Quinta Nursing Home as required.

Most people told us staffing levels were still not sufficient to meet their needs. There had been a small increase in the number of care staff for people on each staff shift but there was still no system in place to demonstrate the adequacy of the staffing levels provided. There was a lack of sufficient staff to provide people's care at the times it was needed for example, in the morning or at lunchtime. As a result records demonstrated some people were awoken at 05:30 and people who required support to eat their meal at lunchtime did not always receive timely support. There was a high use of agency staff and a high staff turnover which resulted in people receiving inconsistency in their care. Agency nurses were regularly in charge of the service at night, this meant the service at night was not always being run by nurses who were sufficiently familiar with the service and people's needs. There was an insufficient level of management currently provided to ensure the service was well managed to ensure peoples' safely.

Staff were receiving supervisions and staff appraisals had commenced. However, the provider was unable to demonstrate that all staff had completed the care industry standard induction requirements. Staff had still not all completed ongoing training to ensure they kept their knowledge and skills up to date. Staff still did not receive robust moving and handling training with an assessed practical element to ensure they could move people safely. The competency of nurses to carry out their role effectively had not been assessed. People were cared for by staff who had received insufficient training and induction into their role.

People's records still did not always contain all of the required information to enable staff to provide people's care safely and effectively.

The provider had not ensured people were protected from the risk of acquiring an infection. They had not ensured preventative measures were in place and robustly implemented, such as; thorough monitoring of staff practices to ensure they had followed infection control guidance. Regular and thorough cleaning of the service or the analysis of two incidents where people had acquired an infection were not in place to prevent a reoccurrence or spread of the infection.

Environmental risks to people had not been managed safely. Required checks in relation to water safety had not always been completed and where defects had been found they had not always been acted upon promptly to ensure people's safety.

Staff had not ensured people could always reach their call bell or that they had a drink within reach. Staff had not always ensured people could access assistance as required for their safety and comfort. This meant people were at risk of not being able to access staff as required.

Most people told us the staff were good. Many staff were observed to interact positively with people; however, there was inconsistency in staff practice. People did not all experience positive relationships with staff. People were not all supported to make choices and not everyone had their privacy and dignity upheld. Not all staff knocked on people's bedroom doors before entering. Not all staff

Summary of findings

ensured conversations with people about personal care were held in private. Staff did not always protect people's dignity and privacy when providing their personal care. Staff did not consistently respect the fact they were working in peoples' home and refrain from the use of mobile phones at work. Not all staff treated people with compassion.

Staff had not all received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLs). As a result not all staff understood their role or responsibilities. There was a lack of evidence to demonstrate that where people lacked the capacity to make a decision an MCA assessment had been undertaken and a best interest decision made on their behalf. DoLs applications had been made for three people but there was no associated MCA assessment to demonstrate how the decision to make each application had been reached. The building was not secure for people who were subject to DoLs and mobile to ensure their safety. There were no door codes on the inside of the front door, so if people were mobile and wished to leave the building they could do so, which could place them at risk.

Since the last inspection only three areas of the service had been audited, in relation to infection control, medicine administration records and staff files. These audits had not identified all of the issues we found at this inspection which required action or improvement. Following completion of the audits there was a lack of resulting robust action plans to ensure improvements were made to the service for people and to ensure their safety.

The provider had not ensured that all of the required information was available for each member of staff in relation to their safe recruitment. The interim manager had completed an audit on 3 December 2015 and was aware of these discrepancies. However, there was no action plan in place yet to ensure to ensure this was addressed for people in order to demonstrate the suitability of staff for their role.

People and staff were generally supportive of the interim manager. People did not consistently provide positive feedback about the provider. Since the provider had terminated the registered manager's contract in August 2015 there had been a lack of sufficient management for the service. The interim manager lacked the support of a deputy manager to enable them to carry out their role effectively.

Staff spoken with were not aware that the provider had a set of values. We requested a copy of the provider's values but these were not provided. Staff behaviour was not always consistent with their duty of care towards people. Staff had taken unauthorised leave which resulted in some shifts not being adequately staffed. The staff rota was not managed at a local level to ensure an effective organisation of staff shifts so that the staff roster was operated smoothly and efficiently for people.

People's relatives had been encouraged to participate in reviews of their care. However, their involvement was not always evident from people's care records. Some people's care records had not been reviewed as regularly as required by the provider. Staff received a verbal handover between shifts and a written handover sheet. However, this did not contain all of the information staff needed in order to provide people's care safely and effectively.

Staff were focused on the practical delivery of people's care. There were a range of activities available to people, however, these were not based on people's assessed needs and interests.

People received their medicines safely. Medicines had been stored safely. People's medicines were administered to them by staff who sought their consent prior to administration.

People told us they felt safe. Most staff had completed safeguarding training and understood their role and responsibilities. Safeguarding alerts had been made to the relevant agency as required. Staff had access to relevant safeguarding guidance.

People told us they were satisfied with the food available, which looked and smelt appetising. Staff knew who had specific dietary requirements and these were met. The risks to people from weight loss had been assessed. People were supported to access health care services in response to their assessed needs.

There was a complaints process and people's complaints had been responded to.

Summary of findings

We found two continuing and three new 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There continued to be an insufficient number of staff deployed to meet people's care needs at the times they needed it to be provided. People experienced inconsistency in staffing due to the high numbers of agency staff deployed and the high level of staff turnover. There were insufficient managers in post to monitor and manage the service safely.

People had not been kept safe from the risk of acquiring an infection. The service was not sufficiently clean.

The provider had not ensured the environment was safe for people. Staff did not always ensure people's care was provided safely.

The provider had not ensured that all of the required pre-employment documentation was available for each member of staff. Even though the interim manager had identified this issue and an action plan was not in place to ensure this was addressed for people.

People's medicines were managed safely.

People were safeguarded as staff had undergone training and understood their role.

Is the service effective?

Inadequate

The service was not effective.

People continued to be cared for by staff who had not completed the recognised industry standard induction or completed sufficient training to be effective in their role. The competency of nurses to carry out their role had not been assessed.

Where people lacked the capacity to consent to their care and treatment legal requirements had not always been met.

People's nutritional needs had been met.

People were supported to access health care services in response to their assessed needs.

Is the service caring?

Requires improvement

The service was not always caring.

Summary of findings

People experienced positive relationships with a number of staff; however some staff had not developed positive relationships with people.

Staff did support people to make choices but did not ensure people were consistently offered choices in the provision of their care.

Some staff did not consistently treat people with dignity and respect.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's records did not always demonstrate their relative's involvement in their review or that their care had been reviewed in accordance with the provider's requirements by staff.

There were a range of activities available; however, they were not always based on people's assessed needs and interests.

There was a complaints process and people's complaints had been responded to.

Is the service well-led?

Inadequate 

The service was not well led.

There was a continued failure to maintain all of the records required for people.

Audits were not being used robustly to drive improvements to the service.

There was an insufficient level of management at the location to ensure there was sufficient leadership and oversight of the service so that people received good quality care.

The provider had still not ensured staff were provided with a written set of values to ensure staff fully understood the behaviours required of them in the delivery of people's care.

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

The inspection took place on 7, 8 and 9 December 2015 and was unannounced. The inspection team included two inspectors and a specialist advisor.

Prior to the inspection we spoke with a public health practitioner, a social worker, a health practitioner from the ambulance service and a specialist nurse from the local clinical commissioning group.

During the inspection we spoke with 11 people and three people's relatives. We spoke with the interim manager, the activities co-ordinator, three kitchen and domestic staff, nine care staff and four nurses.

We reviewed records which included eight people's care plans, five staff recruitment and supervision records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our inspection of 14 and 15 April 2015 there had been a failure to deploy sufficient staff. This was a breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The majority of people told us staffing levels were still not sufficient. A person said "They need more staff as sometimes they are short staffed and they have to run round lots. Another said "We have to wait to go to the toilet."

The interim manager told us nine care staff and two nurses were rostered during the day and four care staff and one nurse at night. There had been a small increase in the ratio of care staff to people since the last inspection. The provider had not implemented a staffing level dependency tool to enable them to demonstrate staffing levels were based on people's assessed level of care needs. Therefore they were unable to provide evidence that staffing levels were sufficient to meet people's needs safely.

There were not always sufficient staff deployed to meet people's needs at the times required. Some people's records demonstrated they were woken and washed from 05:30 in the morning before falling asleep again. The allocation sheet for night staff stated '6am wash and dress 6 clients.' This did not take into account that six people may not be awake and wanting to get up at this time. At lunchtime there were not sufficient staff to support people who required assistance eating their meal. Some people either had to sit and watch other people being served their meal and eating it before they were served and supported by staff, or staff served their meal and did not return to support them until the meal was cold. There were insufficient staff to support people who required assistance at lunchtime.

There was regular use of both agency nurses and care staff. Over the 28 day period of the rosters from 16 November 2015 to 13 December 2015 agency care staff were booked for 52 shifts and agency nursing staff for 21 shifts. Eight of the 19 care staff had commenced work for the provider since October 2015. The high staff turnover had been raised by people at their resident's meeting on 30 June 2015.

There was a lack of evidence to demonstrate this had been addressed. People experienced inconsistency in the staff providing their care due to the high staff turnover and use of agency staff.

A health practitioner informed us the ambulance service had recently been called to the service at night, to a person who was approaching the end of their life. They found the nurse in charge had poor English. They were not aware of the GP guidance in the person's care records with regards to the circumstances under which the person was to be admitted to hospital, for example a medical emergency. The ambulance staff assessed the person and determined it was in the person's best interests to remain at the service and not to be admitted to hospital as per the guidance in their care plan. The staffing rosters demonstrated there was an agency nurse on duty that night. They had failed to read this person's records before calling the emergency services or to use the on-call system to seek advice or to document the incident. Rosters demonstrated agency nurses had been in charge of the location on nine occasions during the period 16 November 2015 to 13 December 2015. This person's care had been negatively impacted upon as the provider had not ensured this agency nurse was competent to be in charge of the service.

Since the last inspection the provider had terminated the registered manager's contract. There was now only the interim manager in post to run the service. The interim manager had formally been the deputy manager and their post had not been filled, to ensure the service was managed safely for people.

The failure to deploy sufficient, competent, skilled and experienced staff to care for people, and manage the service was a continuing breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

A public health practitioner had informed us that two people had contracted an infection. The interim manager told us they had sought and followed guidance on the management of this infection and that only one person still had the infection. They had not completed an assessment of the two incidents in order to identify how these people acquired the infection and any measures required to prevent reoccurrence.

Most staff had received infection control training and had access to relevant policies and procedures. However, a staff

member caring for the person who still had the infection was observed not to change their gloves and apron upon exiting this person's bedroom. As a result there was a risk that this staff member could transfer the infection to others. The person with the infection required their bed linen to be laundered daily as part of their treatment for the infection. There was a lack of clarity amongst staff about whose responsibility this was or evidence to demonstrate this had been done as required. The person's laundry was not correctly labelled to ensure all staff knew how to manage it safely.

We found a lancing device left out instead of being disposed of in a sharps box. This meant people and staff were at risk of touching an item contaminated with blood. A member of the kitchen staff was seen in the kitchen on the first day of the inspection, despite having gone home sick the day before. They had ignored infection control guidance and the interim manager had to send them home again for people's safety. Staff had failed to always follow infection control guidance for people's safety.

Although the cleaners now completed longer shifts, parts of the service were not clean. The sluice room on the top floor was not clean. People's bedrooms were not always clean and there were malodours in parts of the building. There was not a robust process in place to enable the provider to assess the adequacy, frequency and the quality of the cleaning of the service.

In some bedrooms we found extension leads with trailing wires. In two people's bedrooms we saw a hole in the wall where an electric socket had been removed, screws were still sticking out and there was debris. This was a risk to people's safety. Records showed not all of the emergency lights were working when tested on 16 November 2015. No action was taken to address this issue and the service experienced a power cut on the night of 5 December 2015, these lights did not all work when required. The nurse in charge that night confirmed they had not used the on-call system to seek advice as they did not see the need to nor had they completed an incident form. They had not followed guidance to alert senior staff or to correctly document this incident for people's safety. Legionnaires' disease is a form of pneumonia caused by legionella bacteria. To manage this risk taps must be flushed through weekly. For people's safety the water temperature from the taps should also be tested weekly. There were no records to demonstrate these checks had been completed as required. The provider had not ensured people could not gain access to the building works that were taking place at the location for their safety. Environmental risks to people had not been managed safely.

People had risk assessments in place. However, risks to people were not always managed safely. Staff did not always ensure that when people were in their bedroom they had their call bell and a drink within reach. This placed people at risk of not being able to access a drink or alert staff if required. Staff were observed not to ensure they had put the brakes on people's wheelchairs when they stopped, this was not safe for people.

The failure to mitigate risks to people, ensure premises and equipment were safe, and assess, prevent, detect and control the spread of infection were breaches of regulation 12 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

We found one staff member's job application form was missing. Not all of the staff application forms we checked provided their full employment history. This information is required to ensure the provider was aware of any gaps in people's employment history and the reason for them. Two staff member's second references were missing. People's care had not been negatively impacted upon, however, this information had not been provided as required. The provider had checked to confirm nurses were registered with their professional body. Staff had undergone a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had obtained confirmation from employment agencies that relevant checks upon staff had been completed. The interim manager told us they had completed an audit of staff files on 3 December 2015 and identified that information was missing. They told us they had not yet written an action plan to ensure staff provided the required information within a set timeframe. Staff recruitment files did not always contain all of the required information. The interim manager was aware of this and had not produced an action plan to address the shortfalls found during their recent audit.

Medicines were stored at the correct temperature. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. Providers are required to ensure procedures

Inadequate

Is the service safe?

are in place to ensure they are safely managed and that staff follow these to keep people safe. Controlled medicines were stored safely and correctly recorded by two nurses. We found in one person's room staff had not recorded on their creams the date of opening to ensure staff knew how long the cream had been in use. This was brought to the attention of the nurse in charge who dated the cream. A nurse was observed to administer people's medicines safely with consent, respect and dignity. There was a medication policy available for staff. People's medicines were managed safely.

People told us they felt safe within the service. Since the last inspection four safeguarding alerts had been made by the provider to the local authority. This demonstrated the interim manager had correctly identified when safeguarding alerts were required and followed the correct procedure to report them, all had since been closed. On 8 December 2015 the interim manager ran a pre-planned training session for staff on safeguarding using one of the new DVD's they had purchased to supplement staff's distance learning. Staff told us they had completed safeguarding training and were able to demonstrate their understanding. Records showed the majority of staff were up to date with this training. Relevant contact telephone numbers were available to staff in the office. People were cared for by staff who had received safeguarding training, and understood their roles and responsibilities in respect of safeguarding people.

Inadequate

Is the service effective?

Our findings

At our inspection of 14 and 15 April 2015 we found there had been a failure to provide staff with appropriate training, supervision and appraisal. This was a breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Since the last inspection the provider had implemented a staff supervision and appraisal policy. Staff told us they received supervision and this was confirmed by records. The interim manager told us they had commenced the process of annual appraisals for staff although they were not all complete, records confirmed this. People were cared for by staff who received support in their role.

There was still no evidence that any of the care staff had completed the Care Certificate, this was confirmed by the interim manager. The Care Certificate is the recognised industry standard induction to ensure care staff have the skills required to provide people's care effectively. People were not supported by staff who had received an adequate induction to their role.

Records demonstrated few staff had completed the provider's required training or their training had expired in areas such as fire and safety, legionella, Control of Substances Hazardous to Health (COSHH) or dementia care. There was no evidence any staff had completed training on privacy and dignity. 10 out of 26 staff had not completed moving and handling training, four of these were care staff providing people's care. The interim manager confirmed that staff moving and handling training still did not include a practical element delivered by a competent qualified professional to ensure staff were competent to move and handle people safely. They confirmed that they had not documented any observed practice of staff to evidence staff understood safe moving and handling practice and followed guidance. Not all staff had undertaken the provider's required training to ensure people were provided with effective and safe care.

There was a lack of evidence to demonstrate that all nurses had completed refresher training to ensure their knowledge and skills were up to date, in the areas of diabetes, wound care or catheterisation. Although the service cared for people who required these types of care. Training records for medicines management were only available for three of the six nurses and these showed that all of them needed to update their medicines knowledge. Nurses' medicines competency at this service had not been assessed. The interim manager told us they had obtained a staffing competency tool however they had not yet assessed the competency of any of their nurses. Although they told us they had concerns about the competency of one nurse. The provider had not ensured that the competency of the nurses to undertake their role effectively had been assessed.

The failure to provide staff with appropriate training was a continuing breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Three of the six staff we spoke with about the MCA said they had completed training in this area and were able to demonstrate their understanding of the act. However, records demonstrated 25 of the 27 staff had either not competed MCA training or their training had expired. Staff had either not received training in this area or had not had the opportunity to update their knowledge. Staff told us one person liked to be got up by the night staff but when we spoke with them about this they lacked the capacity to understand what we were speaking to them about. This person lacked the capacity to consent to their care but there was no MCA assessment completed on their behalf or a best interest decision to demonstrate it was in their best interest to be got up at 05:30 by the night staff.

The interim manager told us they had recently completed DoLs training. The service had made DoLs applications for three people. There was no evidence to demonstrate what steps the service had taken in order to assess on what

grounds these were required. For example, there was no MCA assessment to demonstrate these people lacked the capacity to consent to receiving care and treatment at the service and that the application was in their best interests. There was no evidence that relevant people had been consulted as part of this process.

The failure to ensure where people could not give their consent the registered person had acted in accordance with the 2005 act was a breach of regulation 11 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

An application for a DoLs is generally made on the grounds people are expressing a desire to leave the building and as a result physical restrictions are in place to prevent them from doing so. The three people who were subject to Deprivation of Liberty Safeguards applications (DoLs) were not mobile and therefore were unable to exit the building independently. However, people were able to exit the front door of the service freely as there was no keycode. The service would therefore not be safe for anyone who required their liberty to be restricted who was mobile.

People told us that the food was alright. One person told us they had “No complaints about the food.” The kitchen assistant who was cooking the meals during our inspection knew who required a pureed diet and ensured this was provided. Where people needed adapted crockery or cutlery to promote their independence this was provided. There was one choice of hot meal; however alternatives such as a jacket potato or salad were available for people. Lunch looked and smelt appetising. People appeared on the whole to enjoy their meal. The risk of people becoming malnourished had been assessed using a recognised screening tool. The interim manager told us no-one needed to be on a food chart. People’s nutritional needs had been met.

Records demonstrated people had seen various healthcare professionals as required including the dentist, GP, physiotherapist, speech therapist and chiropodist. A person told us staff would contact the GP if requested. The service was expecting a GP visit on the second day of our inspection to review the needs of three people. The interim manager was not aware that the GP was on leave that afternoon, and no arrangements had been made for another Doctor to review these people’s needs. The interim manager assured us a fax would be sent to the GP surgery to make them aware of these people’s needs. Overall people were supported to access health care services in response to their assessed needs.

Requires improvement

Is the service caring?

Our findings

Overall people told us staff were good although one person told us some staff members were caring and some were not. People commented "Staff are good to us" and one person said the staff were "Sound." Observations of staff practice over the course of the inspection showed staff interactions with people were not always consistent with people's reported experience.

Many staff were observed to have developed positive relationships with people. A member of the care staff was observed to sit with a person at their level whilst they supported them to eat. Another was seen to interact well with a person they were supporting, chatting to them and asking them if they wanted their jacket, to ensure their comfort. Another care staff member was seen to ask the person if their table was in the correct position and at the right height for them to eat their meal in their bedroom. People experienced positive relationships with a number of the staff.

A person told us "I can choose when to get up and when to go to bed." The interim manager was observed to use a white board with a person who had difficulty communicating to support them to express themselves. A person was heard to tell staff they did not like their lunch, staff responded appropriately and offered the person an alternative. A number of staff were observed to support people appropriately to make choices about their care.

However there was inconsistency in staff practice. Not all people experienced positive relationships with staff, or were supported to make choices or had their privacy and dignity upheld. A staff member was observed to walk straight into a person's bedroom without knocking first to check if the person wanted them to enter their private space. The staff member did not close the bedroom door and could be heard from the corridor telling the person they were going to provide them with personal care. The person stated they did not need personal care at this time but the staff member continued to insist they needed it, rather than respecting the person's views and returning later. On the second day of the inspection we knocked on a person's bedroom door. The same member of care staff opened the person's bedroom door without first calling out and checking who we were or what we wanted. This left the person exposed whilst receiving personal care. At lunchtime a person was exposing part of their upper body. Staff did not notice or offer support to this person to cover themselves. Staff had not received training in upholding people's privacy and dignity to ensure they understood their responsibilities. Staff had not consistently upheld people's rights to privacy and dignity.

Following a complaint received in May 2015 about staff using their mobiles on shift all staff had been advised not to use them. A care staff member was seen in front of a person texting on their mobile phone. They did not stop even when another member of staff pointed out they were being observed. This staff member was not treating people with respect. Although staff had been told not to use their mobiles on shift this staff member had done so. People were not always treated with respect.

Staff were observed seating people for lunch on the second day of the inspection, however the tables had not been laid. People's meals were being served whilst the tables were being laid this was not respectful. There were no condiments on the table. People were offered a tissue instead of a napkin at lunchtime. Staff were observed to place people's meals down without taking the opportunity to speak with them. They did not always tell people who needed to be told, what was for lunch. Staff did not always give people a choice of what drink they wanted with their lunch. People were not always being treated in a caring and compassionate way.

We observed that many people spent a lot of time in their wheelchairs. In the lounge few people were transferred by staff into comfortable chairs. At lunchtime staff were positioning people's wheelchairs around the dining table. As not everyone's wheelchairs fitted around the table they removed a person's footplates and left their legs hanging. The person was heard to say "I don't want to sit here too long as my legs are hanging." Staff had not treated this person in a caring and compassionate manner. The interim manager told us people preferred to stay in their wheelchairs, but it was not recorded in people's care notes that they had been consulted about their wishes and that this was their choice. Staff did not demonstrate care and compassion for people by checking with them if they wanted to remain in their wheelchairs.

The failure to treat people with dignity and respect were breaches of regulation 10 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

People we spoke with told us nurses did not talk to them much about their care plans. There was a notice displayed on the front door asking people's relatives to make arrangements with the nurses to review their relatives care. There was a lack of evidence in people's records to demonstrate this was always happening. For example, for one person there was evidence the person's relative had provided information about their care preferences and that their care plans had been reviewed monthly by staff. This person's relatives had been involved in a review of their care in June 2015. However, another person had been admitted a few weeks earlier. Their records did not contain an activity care plan. There was no continence care plan or advanced care plan. There was no cognitive functioning and depression care plan. The person was partially sighted but this was not reflected in their care plan. Staff did not have access to full written information about this person's care needs. There was a lack of evidence to demonstrate this person's relative had been involved in their care planning. The involvement of people and their relatives in care planning and reviews was not always demonstrated consistently in their records.

A nurse told us they had not been able to keep up with writing people's care plans and care plan reviews. A person's care plans had not been reviewed since August 2015, instead of monthly as required. Staff had not ensured that everyone's care plans were reviewed as required.

Staff were arranged into groups and allocated a group of people to care for across the shift. This ensured people were cared for by designated staff. Staff told us they received a verbal handover at the start of each shift and had a written handover sheet. This provided limited information about people's diagnosis and needs. There was no record on the handover sheet of who was subject to the Deprivation of Liberty Safeguards (DoLs) for staff to be aware of the restrictions in place for these people. Following a recent incident the interim manager had ensured people's 'My care plans' from the GP were placed at the front of their care records for staff as they contained details of the circumstances under which people should be admitted to hospital. However, there was nothing on the handover sheet to provide guidance for staff about people's individual needs in relation to hospital admission or to instruct them to look at the care plan. Handover records did not provide comprehensive information for staff about people's individual care needs.

Staff were observed to be very task focused. There was limited opportunity for them to sit down with people and to interact with them and form relationships. A staff member told us they had not been asked to read people's care plans since they started work for the provider. Another said there was a lack of time to talk to people and that they did not get enough information about people. People's care was provided by staff who were focused on the physical tasks of providing care.

There was a monthly activities schedule with a variety of activities taking place across the week. These included games, craft, hairdresser, skittles, music, physiotherapy, quizzes and flower arranging. Some people told us they did not find the activities on offer stimulating. They told us they wished to go out into the community but said they were not taken out. They enjoyed the social activities such as the summer BBQ and expressed a wish to see more such activities. The provider's action plan following the last inspection stated they had met with people on 22 April 2015 and planned two visits on home expenses, these had not taken place.

Records demonstrated the findings from the last inspection in relation to people's participation in activities had been discussed with the activities co-ordinator. They told us they had spoken with other external activity co-ordinators about the activities they provided. They told us since the last inspection they were documenting more clearly people's participation or observation of activities, this was confirmed by records. It was not clear this information was actively being used to gauge people's response to activities and therefore as a way to plan future suitable activities. They demonstrated their understanding of people's preferences and interests but acknowledged that it was difficult to meet everyone's needs within the building. Although there were a range of activities arranged not everyone found what was on offer of interest to them. Activities were not clearly linked to people's assessed need, interests and preferences to ensure these were met.

Requires improvement

Is the service responsive?

The complaints process was displayed in the hall for people. There were four written complaints received since the last inspection. These had been investigated and feedback provided. People's written complaints had been responded to.

Inadequate

Is the service well-led?

Our findings

At our inspection of 14 and 15 April 2015 we found there had been a failure to ensure accurate and complete records were maintained in relation to each person and other necessary records. This was a breach of regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Two people's medicine administration records (MARs) had not been signed by staff to demonstrate their creams had been applied. A person's care plan documented they had a catheter. The interim manager told us they no longer needed this. This person's records had not been updated to reflect this change. The interim manager told us a person required repositioning every four hours when in bed however there was no guidance for staff about this or evidence in their daily records that they had been repositioned. At the last inspection we had found there was poor recording of the amount of fluids people had taken to enable staff to assess if people were at risk from dehydration. This had been addressed with staff at a staff meeting on 23 September 2015. The interim manager told us three people used catheters. We checked one of these people's records and there was no record of their fluid output, to ensure this was monitored for their health and welfare.

People had charts in their bedrooms to demonstrate that their welfare had been checked upon each hour. These records had not always been updated hourly for people to provide a record of the care people had received. A person had received treatment for a pressure sore and they were nursed on an air mattress to manage this risk to them. There was no documentation to show that the air mattress was on the correct settings according to the person's weight, neither was there evidence that nursing staff had checked the correct setting to ensure the person's comfort. There was no photographic evidence of the person's wound. People's records had not always been updated following falls to ensure any required changes had been made to their care plans. People's monthly weights did not include the date they were taken. This meant there was not a clear record of when people's weights had been taken in order to assess their weight gain or loss. Accurate, complete and contemporaneous records of people's care had not consistently been completed by all staff as required.

The providers' failure to ensure accurate and complete records were maintained in relation to each person was a continuing breach of regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The interim manager told us and records confirmed, that they had audited people's MARs to check nurses had signed for medicines administered. People's MARs for their creams had not been audited to check care staff had completed them correctly. The system for auditing people's MARs was not effective at assessing and monitoring the risks associated with people not receiving their creams because these were not included within the audit.

An infection control audit had been completed by the interim manager on an unspecified date in November 2015. It noted infection control audits and checks were not up to date. The audit did not identify the issues around infection control we identified at this inspection. We identified issues in relation to the standards of cleanliness of the environment, the quality of the cleaning completed by staff, and the incorrect use of personal protective equipment by staff. The infection audit had not been effective at assessing, monitoring or mitigating the risks associated with infection control.

The interim manager had audited the staff recruitment files on 3 December 2015 but there was no associated action plan and timeframe to ensure staff provided the required information required in a timely manner.

We asked the interim manager if there were any other audits completed since the last inspection. They told us they could not find the audits. There was a lack of evidence to demonstrate any other areas of the service other than MARs, infection control or staff recruitment records had been audited. There was a lack of a robust audit system in place covering all aspects of service provision resulting in clear action plans to ensure improvements were made to the service for people and to ensure their safety.

Following the last inspection the provider had submitted an action plan outlining how they would ensure the breaches found in the regulations would be addressed. However at this inspection we found these breaches had continued and not been fully addressed. There was not a robust system in place to ensure the provider's action plan was implemented fully and effectively.

Inadequate

Is the service well-led?

The provider's failure to operate effective systems to assess, monitor, improve and mitigate risks to people was a continuing breach of regulation 17of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Staff said they felt fully supported by the interim manager and people were generally positive about the interim manager. However, people did not provide consistently positive feedback about the provider. One commented that the provider was not caring.

Since the last inspection there had been a reduction in the number of managers in post from two to one due to the provider terminating the registered manager's contract. The interim manager did not have enough time to manage the service and ensure there was sufficient oversight of the care delivered and clinical issues to ensure people received high quality care. The interim manager was not sufficiently supported within their role through the provision of a deputy manager to support them in running the service. The interim manager was trying to manage the service and make changes however they needed more management resources to enable them to carry out their role and improvements to the service effectively.

Although the interim manager told us the nurses were supposed to lead the shift, they also said nurses did not oversee the care staff. The nurses we spoke with were focused on nursing tasks and there were only three senior care staff. There was a lack of clarity about who was responsible for the quality of the work of care staff and for leading them in the delivery of high quality care for people.

The interim manager told us the provider had offered them the post of manager but they had not received a contract as yet. At the time of the inspection the service did not have a registered manager in post as legally required.

Staff told us they had not covered the provider's values as part of their induction. At the last inspection we had found that the provider did not have a set of written values for the service. Value statements outline the standards care staff are required to deliver and the behaviours they should demonstrate in their work with people. The provider's action plan had stated the values would be sent out monthly with staff payslips. We requested a copy of the provider's values. The interim manager told us they had been written but was unable to supply a copy.

Records demonstrated a staff member had a disciplinary supervision in November 2015 having taken two days unauthorised leave. On the second day of the inspection the interim manager told us another member of the care staff had left the shift unauthorised. This had left the care staff team short of one member of staff to deliver people's care. The behaviour of these staff did not demonstrate that they wither understood or upheld their duty of care to people when carrying out their duties.

The interim manager told us there was a cultural divide between the Asian staff and the Eastern European staff. This manifested itself with different groups of staff refusing to work with each other. They were trying to address this through the staff meetings. They told us the staff roster was still being managed by head office and this resulted in staff approaching head office directly to make amendments to the roster rather than going through them as the interim manager. This process did not support the interim manager in their leadership of the staff team.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The failure to treat people with dignity and respect were breaches of regulation 10(1)(2)(a) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Quinta Nursing Home. The Registered provider must not admit any new service users to Quinta Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The failure to ensure where people could not give their consent the registered person had acted in accordance with the 2005 act was a breach of regulation 11 (1)(2)(3) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Quinta Nursing Home. The Registered provider must not admit any new service users to Quinta Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The failure to mitigate risks to people, ensure premises and equipment were safe, and assess, prevent, detect and control the spread of infection were breaches of regulation 12 (2)(b)(d)(e)(h) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Quinta Nursing Home. The Registered provider must not admit any new service users to Quinta Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1)(2)(c) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014. The providers failure to ensure accurate and complete records were maintained in relation to each person was a continuing breach of regulation 17(1)(2)(c) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014. The providers failure to operate effective systems to assess, monitor, improve and mitigate risks to people was a breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Quinta Nursing Home. The Registered provider must not admit any new service users to Quinta Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The failure to deploy sufficient, competent, skilled and experienced staff to care for people, and manage the service or to provide staff with appropriate training was a continuing breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Quinta Nursing Home. The Registered provider must not admit any new service users to Quinta Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.