Exminster Limited - The Manor

The Manor Exminster

Inspection report

Main Road, Exminster,
Exeter, EX6 8AP
Tel: 013 9282 4063
Website: : http://stone-haven.co.uk/care-homes/the-manor/

Date of inspection visit: 13 and 19 August 2015
Date of publication: 04/11/2015

Ratings

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

Overall summary

The inspection took place on 13 and 19 August 2015 and was unannounced. 22 people were living at the home when we visited. We last inspected the service in May 2014 and did not identify any breaches of regulations in the standards inspected.

The Manor Exminster provides accommodation with personal care for up to 25 older people, it does not provide nursing care. The home has a 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.

The service lacked consistent leadership. Relatives and professionals feedback showed the home was more organised and well run some days than others, depending on who was in charge and staffing levels. Since the departure of the previous registered manager at

Summary of findings

the end of 2013, there have been several changes of leadership. In March 2015, a director in the company became the registered manager. This is an interim arrangement, whilst a new manager is being recruited.

The provider had a range of quality monitoring systems , these included audits of medicines and care records, regular meetings with people, and staff and two monthly provider visits. However, some systems were not effective and others had lapsed. The provider monitoring visits highlighted several areas for improvement, which included three of the four breaches of regulations identified at this inspection. However, no actions were taken in response, which meant the system of quality assurance was not robust.

Staffing levels at the home were not sufficient to meet people's needs at all times. Rotas and staff feedback showed staff shortages occurred regularly and staff were working excessive hours. The service had a long term vacancy for cleaning staff, and a more recent vacancy for a chef. These vacancies meant care staff were stretched as they had to work extra hours to do cooking, cleaning and laundry in addition to providing people's care. This meant staff were rushed and were not always able to provide care in response to people's needs or interact with at a time convenient for them. Health professionals thought the service was short staffed, but said people's needs were safely met.

Staff offered people choices and supported them with their preferences. However, where people appeared to lack capacity, mental capacity assessments were contradictory and were not completed in accordance with the Mental Capacity Act (MCA) 2005. This meant there was confusion about whether or not people had the ability to give consent about day to day decisions.

People and relatives were happy with the service provided at the Manor. Staff knew people well and were caring towards them. People said staff treated them with dignity and respect although we witnessed one episode of poor practice. However, the care provided were very task oriented, in that it was organised around routines of the home, rather than in response to people's individual needs and wishes.

People, relatives and visiting professionals commented on the lack of meaningful activities for people. Some people said they were bored and many people spent most of their time sitting around without much to occupy them.

People were supported to maintain their health and to access ongoing support from health care services. People received their prescribed medicines in a safe way.

People 's feedback about the food was mixed, some people were satisfied and others said the quality of food was variable. Although there was a choice of main meal each day, not everyone was aware of this.

Staff were aware of signs of abuse and knew how to report concerns and most were confident these would be appropriately investigated. A robust recruitment process was in place to ensure people were cared for by suitable staff. Staff were knowledgeable about people's care needs, had qualifications in care and received regular training and updating.

We identified four breaches of regulations at this inspection. 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?

Requires Improvement

Some aspects of the service were not safe.

There were not enough staff to meet people's needs and preferences. This meant people put people at risk of not receiving assistance and care at a time convenient for them.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

Risks for people were assessed and actions taken to reduce them.

People received their medicines in a safe way.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff offered people choices and supported them with their preferences. However, people's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005.

People accessed healthcare services appropriately, staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

Staff received regular training and ongoing support through supervision and appraisals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People said staff treated them with dignity and respect, although we saw an example of poor practice.

Staff were kind and affectionate towards people and formed positive and caring relationships with them.

People and relatives were consulted and involved in decision making about their care and treatment and signed their care records.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Summary of findings

Although staff were friendly and supportive towards people, care was often task focused, rather than meeting the individual needs of people at a time convenient for them.

People's care records were brief and not very individualised, which meant there was a risk of people not having their care needs and wishes met.

There was a lack of stimulation or meaningful activities for people and some people were bored.

People knew how to raise concerns. Any concerns raised were investigated, and appropriately responded to.

Is the service well-led?

Some aspects of the service were not well led.

The service was more organised and well run some days than others, depending on who was in charge and on staffing levels.

Although regular audits were carried out at the service, some quality monitoring arrangements were not effective and others had lapsed.

Where the need for improvements had been identified, these had not been acted on.

Requires Improvement

The Manor Exminster

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.

This inspection took place on 13 and 19 August 2015 and was unannounced. The inspection team included an expert by experience and an inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a dementia care service. Prior to the inspection we reviewed information about the service from the Provider Information Return (PIR), although some aspects of the PIR received were not completed in full. We also looked at other information we held about the service such as feedback we received from health and social care professionals, relatives and from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not talk with us.

We met all 22 people using the service, and spoke with seven relatives and friends. Some people had lived at the home for some years and others had recently been admitted. We spoke with the registered manager, another director in the company and with six staff. We looked at four staff records, and at staff training and supervision records, and at a range quality monitoring systems the provider used such as audits and provider visit reports. We sought feedback from commissioners, and health and social care professionals who regularly visited the home including GPs, community nurses, and therapists, we received a response from six of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and secure at the home and trusted staff to care for them. We received some feedback raising concerns about the adequacy of staffing levels at the home which we followed up at this inspection. Although people were offered safe care, we found staffing levels were insufficient and were adversely affecting the quality of care provided.

We asked about normal staffing levels at the home. Staff said there should be four care staff on duty in the morning, and three in the afternoon. At night there was one awake night staff and a sleep in member of staff, who staff said was rarely woken. Staff were very busy and only had brief interactions with people. For example, when completing personal care tasks, administering medication and whilst staff were passing through the lounge on their way to another part of the home.

When we arrived on the first day of the inspection at 0945, staff appeared very busy. A member of staff was off sick, which meant there were three care staff on duty, instead of four for 22 people. One of those three staff was in the kitchen cooking lunch. The start of the morning medicines was delayed because the staff doing the medicines was needed to help people get up and have personal care. During this same period, the dishwasher had broken and there was a power cut. However, maintenance personnel were on site and addressed these issues quickly.

People in their rooms had access to call bells, and said staff take five to ten minutes to answer the bell. One person said "It depends what time of day it is" and another said, "It depends how many staff there are." Some relatives said they thought the home was short staffed sometimes. One relative said, "Very often there are not enough staff." They said sometimes, there were delays in making people's beds and in removing urinals from people's bedrooms and more odours when the home was short staffed. Another relative said, "I feel they could do with more staff, its feels particularly light at night with only one awake staff and one asleep." Staff were rushed and were not always able to provide care with people at a time convenient for people.

People were sitting around for long periods without much to do and staff had limited time to interact with them. Health professionals thought the service was short staffed. They said, although people's care needs were met, people were sitting around for long periods without much to do because staff were so busy. They also expressed concerns about the number of roles care staff were expected to undertake, which they thought were making staff less available for looking after people. One said, "Sometimes staff seem a bit stressed."

The chef had recently left and care staff had taken over the cooking. There was a long term vacancy at the home for cleaning staff since 2014 so care staff undertook cleaning, housekeeping and laundry at the home. On the first day of the inspection, the staff member due to cook lunch was off sick, so the deputy manager was working in the kitchen preparing lunch. A second staff member was giving people their morning medicines, but had started late and didn't finish until 1155. These staff shortages meant for part of the morning, there was only one member of staff available to support people with their personal care.

Most staff felt they could do with more staff, particularly cleaning staff. Four staff said currently, they were working up to 60 hours a week to cover vacancies, staff leave and sickness. One said they thought the home needed some bank staff who could work flexibly to cover sickness and leave. Staff said they were expected to work additional hours when needed. Whilst some staff were happy to work the extra hours, other staff were less happy about these arrangements. One staff said, "My family are not very happy, I'm hoping it will get better." Another said, "We are tight for staff, getting staff to stay is difficult."

Staff described the impact of staffing shortages on people's care. One said, "We can get everything done but it feels rushed, we are not able to do activities and talk to everyone, we could do with more staff." Other staff responses included delays giving people's their medicines, not always being able to offer people a bath or shower, just a strip wash and not being able to spend much time cleaning.

In the provider information return (PIR), the registered manager said there were sufficient trained staff on duty to meet the people's individual needs and keep them safe. However, they did not complete the section asking for the details of staffing levels. The registered manager confirmed they had vacancies for a cook and cleaning staff which they were trying to recruit staff for. They said one care staff was now working in the kitchen regularly. All care staff undertook day to day cleaning and laundry duties as part of their role. This meant people's care was fitted in around

Is the service safe?

daily tasks and routines. The service did not use agency staff, as existing staff worked any extra hours needed to cover staff absence for leave and sickness. Although this was positive for people, as they were cared for by staff who knew them well. However, as the staff group was small, these arrangements meant existing staff were working excessive hours.

We asked how staffing levels at the home were calculated. The registered manager said current staffing levels had been in place for some time and were based on their experience. Although people's individual level of need and dependency was assessed, this information was not used to inform or check staffing levels were suitable to meet people's needs. The registered manager explained they did vary staffing levels according to people's needs, or for any planned outings or activities. They said, staff just needed to say when they needed extra and additional staff were organised. They had arranged for additional staff for a planned outing the following week and staff to undertake cleaning on the second day we visited.

The registered manager explained staffing was particularly tight at the moment because it was peak holiday time and because of sickness. Also, because some newer staff already had holidays booked when they came to work at the home, which they had to honour. The rota showed the recommended staffing levels were regularly not achieved on several occasions. In addition, because 'sleep in' staff were only working part of the shift, this meant the numbers on duty reduced between two and five in the afternoon and after ten in the morning. The rotas did not accurately record the hours staff 'sleep in' staff were actually working. For example, the rota showed the 'sleep in' staff worked from five until eight in the evening and from eight until ten the next morning. In practice, staff said they worked until eleven at night helping to put people to bed and started at six the next morning. Several staff were working six days a week and on occasions up to 14 hours a day. These long hours could impact on the quality of care provided.

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

Relatives said the home was clean, but at times, there were odours of stale urine. On the first day we visited, a couple of people's rooms smelt of stale urine as did one area along one corridor downstairs and several areas needed vacuuming. On the second day, the odours were minimal as a member of staff was undertaking dedicated cleaning duties and shampooed the carpets in those areas. This showed the level of cleanliness and management of odours was related to staffing levels.

Staff received training in safeguarding adults and were familiar with the types of abuse and how concerns about abuse should be reported. Staff said they could report any concerns to the registered manager or deputy manager. Most staff said they were confident they would be dealt with. One staff member said they would put any concerns in writing to be sure and another said they would contact an external agency as well. The provider had safeguarding and whistle blowing and policies available so staff were clear how to report concerns. The registered manager confirmed there had been no safeguarding concerns identified since the previous inspection. Accidents/ incidents were recorded for individuals in their records, although some minor injuries were not recorded on body maps provided for staff to do so. This meant some marks or bruises on people's skin were not recorded and monitored. This could pose risks for people as skin wounds may get worse and unexplained bruises may go unnoticed.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. All staff had police and disclosure and barring checks (DBS), and checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Risks for individuals were managed. People's care records included individual risk assessments about risks such as malnutrition and dehydration, pressure sores, and risks of falling. For example, one person was identified at high risk of falling. The provider had specific care plans for falls prevention which identified general measures to reduce the person's risk of falling such as keeping their room clutter free and ensuring they had everything they needed nearby. However, there was no individualised information about how to reduce their falls risks, although staff told us the person had been seen and assessed by the falls team. Staff explained they had located the person in a bedroom near staff, so they could check on them regularly, which they did, although these checks were not recorded. The

Requires Improvement

Is the service safe?

person chose to keep their room door closed, but had agreed to have a pressure mat near them to alert staff when they moved. This meant staff could check on the person and offer them assistance.

People received their medicines in a safe way although on the day of inspection morning medicines were late being administered. Most people said they usually received their medicines on time, although one person said, their medicines were "sometimes a bit late." The home used a monitored dosage system on a monthly cycle. During the period we visited, staff had identified a pharmacy dispensing error and had alerted their local GP surgery and pharmacy supplier. Two people's medicines had been mixed up and the wrong medicines supplied for each of them. Staff noticed the error and their vigilance prevented people getting the wrong medicines. The registered manager said there had been ongoing problems with their pharmacy supplier. They met with the local pharmacy supplier during our visit to try and resolve these issues.

Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines stocks were checked and medicine administration records (MAR) were audited regularly with action taken to follow up any discrepancies or gaps in documentation. We checked some people's medicines and found they were correct. Tablets and other medicines administered were accurately documented in people's MAR sheets. However, when we accompanied a staff member doing the medicines , we found they were signing to confirm administration of everyone's prescribed creams and ointments, on behalf of other staff who may have administered them. This was not in accordance with the home's policies and procedures. We discussed this with the registered manager who agreed to address this.

Staff said they had enough equipment to support people's care needs such as electric beds, bed rails and bumpers and pressure relieving equipment, and all equipment was regularly serviced and maintained. There was a lack of dedicated storage for furniture and equipment which meant some equipment was stored in corridors and alcoves such as wheelchairs, hoists and spare beds. This gave some areas of the home a more cluttered and institutional appearance.

The provider had completed environmental risks assessments for each area of the home which were updated regularly and showed measures taken to reduce risks. For example, radiator covers and non slip mats in the hallway. However, the monthly health and safety audits of the home previously completed had lapsed, although the environment was monitored regularly as part of the provider monitoring visits.

We followed up some concerns raised with us about maintenance and repairs of the building. For example, a health professional told us about water leaking through light fittings following heavy rain a few weeks ago. We spoke with the director who said the Manor was an old building, and as such maintenance and repairs were ongoing. The company had an estates team who maintained the building. A maintenance person visited weekly and undertook repairs. For example, one person's door was very stiff and opened only a small amount, which was repaired when we visited the second day. We were satisfied the building was safe and that regular repairs and maintenance were carried out.

Regular checks of the fire alarm system, fire extinguishers, smoke alarms, emergency lighting and fire exits were undertaken. Individual fire risks assessments were in place and each personal had a personal emergency evacuation plans in place showing what support they needed to evacuate the building safely in the event of a fire. A written contingency plan was in place in the event of a major emergency requiring evacuation of the home.

Requires Improvement

Is the service effective?

Our findings

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

The mental capacity assessments completed were contradictory and showed staff completing them did not fully understand the requirements of the act and were not acting in accordance with it. When staff completed a first stage assessment of capacity, the responses selected suggested people had capacity, or had fluctuating capacity. However, in each case, staff had concluded the person lacked capacity. This meant there was confusion about whether or not people had the ability to give consent about day to day decisions. We asked a staff member to describe how they undertook the assessment. They described seeking relatives and representatives views about the person's capacity to understand and retain information, rather than undertaking their own assessment of the person's ability. This was not in accordance with the MCA and code of practice.

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

We discussed this in detail with the registered manager and deputy manager, and made them aware of the resources available to assist them with this. Where more complex decisions were being made, there was evidence that staff, relatives and health and social care professionals were being appropriately consulted and involved in 'best interest' decision making. We spoke with a friend who had Power of Attorney for the person and they confirmed they were involved in discussions about the person's care. They said, " It's been absolutely brilliant for her here…she's been here five years and it's her home…they talk to me about how she is and phone me about any changes to her care…the staff here were brilliant …I can't fault them in any way whatsoever."

Staff promoted people's choice and sought their consent for all day to day support and decision making. One person said, "They're very good people…they always ask our permission before doing anything." Two people who came down to breakfast at 10.30 said they preferred to go to bed late and to get up late.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Although people could move around the home, their liberty was restricted for their safety and well-being. This was because all doors to the home were locked and a keypad access system was in use.

The service had made a number of applications to the local authority DoLs team to deprive people of their liberty and were awaiting local authority staff to visit to assess individuals. This was in recognition of the Supreme Court judgement on 19 March 2014 which widened and clarified the definition of deprivation of liberty. It confirmed that if a person lacking capacity to consent to arrangements is subject to continuous supervision and control and not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

People were happy with the skills and knowledge of staff who knew how to meet their needs. The provider information return (PIR) did not include the details requested about staff training, so we followed these up further at the inspection. Several staff had qualifications in care and were experienced, some staff were exploring undertaking additional qualifications. The service had a mandatory training programme which all staff had to complete. This included for example, first aid, food hygiene, medicines management, infection control, health and safety and dementia. Staff received practical moving and handling training and practised using the equipment. A training matrix of staff attendance at training was kept and was monitored regularly by the deputy manager. This showed most staff were up to date with training or had training booked, although showed the registered manager had not attended the required mandatory training.

Most staff gave us positive feedback about working at the home and said they received the training and support they needed. However, two staff said they were expected to undertake all online training in their own time, which they

Is the service effective?

were not very happy about. Staff received regular supervision where they had an opportunity to discuss their work and development needs, although the deputy manager had not received supervision for some time. Only one staff member had received an annual appraisal but others appraisals were planned.

We asked two staff about their induction when they first started working at the home several months ago. One staff said they didn't get much support whereas the other staff said they felt well supported and worked alongside other staff to get to know people and their needs. In the PIR, the provider said they used Skills for Care induction documentation to record staff induction. However, when we asked to see these, we found they had not yet been completed for the two staff we looked at.

People and relatives gave us positive feedback about the care they received. One person said, "They are looking after me extremely well." Another said, "They (staff) give us our medicine and the doctor and the district nurse come in to see us." A relative of a person recently admitted to the home said, " She's got a patch of skin on her leg and when I said I'd have to bring in her plasters, staff said – don't you worry we'll get the district nurse in to change her dressings." Relatives confirmed people saw health care professionals regularly and that staff quickly informed them of any changing needs. One relative spoke about a person temporarily living at the home. They said although the person was depressed, they had already improved living at the home. They said they were taking their prescribed medication, something they had refused to do prior to their admission Their health had improved as a result, which their family were delighted about.

People had regular health visits from community nurses, GP's, chiropodists and occupational therapists. For example, staff called the doctor to see a person who was unwell and was diagnosed with a chest infection and given antibiotics. One health professional said, "When staff call out the GP, they usually have a well-founded reason to do so."

Health and social care professionals reported, staff contacted them appropriately about people's healthcare needs and followed the advice given. One health professional commented staff were sometimes a bit slow to implement their recommendations, for example, in relation to pressure area care. Another health professional thought staff were better at caring for more able people, they went onto explain that they felt staff struggled more to care for people with more complex needs. When we asked health professionals whether they could identify any areas for improvement, one health professional said, "More training in healthcare for the staff."

Each person had an assessment of their health needs before they first came to live at the home. The service used evidence based tools to identify people care needs. Prior to the inspection, we received concerns about staff knowledge in managing people's skin care and reducing their risks of developing pressure ulcers. In several people's care plans, an assessment had been undertaken of the person's skin using an evidence based assessment tool. Where people's assessments showed the person was at risk of skin breakdown due to their fragile skin and lack of mobility, staff did not have detailed care plans to instruct staff about how to manage this. This could mean there was a risk of inconsistent care being delivered.

However, staff knew about people's health needs and were managing them well. For example, people at risk had pressure relieving cushions and mattresses, and staff knew about their skin care. Staff had recently undertaken tissue viability training. Care records included more detailed information for staff about people's moving and handling needs and any equipment needed. In some people's care records there was information for staff about people's specific health conditions.

Many people at the Manor were living with dementia but were fairly mobile. Some people whose rooms were upstairs, people could use the stairlift to access their own rooms and to come downstairs. The provider had arranged for the bathroom/toilet doors to be painted in a contrasting colour and had invested plain, rather than patterned carpets, which are known to be easier for people with cognitive difficulties.

The home was comfortably furnished but lacked visible signage to help people move around more independently. Throughout the inspection, several different people repeatedly had to ask staff where their room was and for help to find the nearby toilet. This was because rooms had numbers but no other identifying features on the doors, such as names or pictures to assist people living with dementia to find them independently. There was no visual signage on toilet/bathrooms areas to indicate their purpose or help people locate and recognise them. The registered manager said they thought the measures

Is the service effective?

already taken were sufficient for the abilities of the people currently living at the home. **We recommend that the service take further steps, based on current best practice, to improve the environment to make it more suited to the specialist needs of people living with dementia.**

People's feedback about the quality of food at the home was mixed. One person said: "The meals are quite nice. . .you don't get a choice but if you don't like it you can send it back." Other comments included, "Its good and bad", and "It's not too bad " and, "Well you've got to eat it or you'd be hungry." People were asked for feedback about the food at a residents meeting on 22 June 2015 which nine people attended. The minutes showed those people were happy with the food, although one person requested smaller portions.

People had enough to eat and drink and there were no concerns about weight loss for any individual living at the home. People were offered food and drink throughout the day, there were regular rounds of hot drinks and people had jugs of water and squash available in bedrooms and communal areas. At lunchtime, 12 people ate in the dining room, and another person chose to eat later in the dining room. Some people preferred to stay in their own rooms for meals. Everyone was served sweet and sour chicken for lunch. People's portions were generous, although a couple of people told us they had asked for smaller portions. A lot of people didn't seem to like the sauce and left it on their plates.

Although staff confirmed there was always a choice of main meal each day, some people didn't seem aware of that. A display board near the kitchen showed the menu for lunch was sweet and sour chicken, mashed potato and vegetables or a cheese omelette but only a few people accessed this area. Staff showed us a four week menu they followed. People said they were 'sometimes' asked about choices but we could not tell if other people understood the choices or how they were helped to do so. This was because people were asked to select their food choices the day before, but many had forgotten and there were no written menus or pictures of meals for people to look at to remind them.

Staff said currently, no-one had any special dietary requirements. Several people were diabetic and staff showed us low sugar jam and other foods they had suitable for diabetics. One person who remained in their room was reluctant to eat and needed encouragement to do so. At lunchtime they ate the mashed potato and broccoli but not the chicken. When staff brought their pudding (bread and butter pudding with cream), they refused it, but they were not offered any alternative, although the registered manager confirmed they should have been.

Requires Improvement

Is the service caring?

Our findings

People said staff treated them with dignity and respect. They said staff made sure they had privacy when supporting them with personal care. However, on the second day of our visit, we witnessed an example of poor practice in relation to one person's privacy and dignity. This related to a doctor visiting to see a person who was unwell. When the doctor arrived staff took the person to a room off the lounge and adjacent to the kitchen, where the consultation and examination took place. This did not afford the person privacy or dignity. The registered manager confirmed staff should have taken the person upstairs to their room for the doctor's visit.

A number of people spent a lot of time in their room and said they didn't want to sit in the lounge area, but there was no evidence to demonstrate that staff were doing to prevent people becoming isolated. The home did not have much outside space, there was a flowerbed bed within the car park where staff said people sometimes sat outside when the weather was fine. However, people would only be able to use that space safely, when staff were available to accompany them.

The home is situated in the village of Exminster but currently people were not accessing their local community regularly. Previously people had regularly gone to Tesco's and to a local 'coffee on the corner' group but currently staff were not available to accompany people to go out much. One person's relative took them to the gym each week to help them maintain their mobility, which they really enjoyed.

Minutes of a residents meeting on 22 June 2015 showed people's views about the day to day running of the home were sought. Issues discussed included timing of meals, menus and forthcoming trips and activities planned. However, people's feedback recorded was minimal and only related to confirming they were happy with the food and a request for smaller portion sizes.

People spoke positively of the care they received from staff with no-one reporting any unkindness. One person said, "It's so nice here..I left another home because the staff were always having rows …it's marvellous and there isn't a better word I can say…it feels very nice to be here." Another person said, "I love it here…the staff are lovely and this one is my prize person...she has a good sense of humour...there aren't any horrible people here, not one." A couple who recently moved into the home from hospital said, "We're helped with washing and dressing and given all our food." People's relatives and friends were welcome to visit the home at any time, and they popped in regularly and chatted easily to staff while we were there. A relative said, "You won't find much wrong here, its lovely." Another relative said, "Some staff are more encouraging than others."

Health and social care professionals described staff as "well meaning" and said they "are doing their best with what they have got." One care professional said, "The carers are nice, they try their best…there is too much to do to give really good care."

Care staff were pleasant, friendly and open. They staff spoke about people affectionately and seemed to know them well. Some staff were from overseas and English was not their first language, but people did not report any difficulties understanding staff. A health professional also said they occasionally witnessed people being spoken to in a slightly abrupt manner. A relative said cultural differences meant some staff could occasionally come across as fairly brusque.

People and relatives were consulted and involved in decision making about people's care and signed their care records confirm this. People's records included information about people's strengths and about what they needed support with. For example, one person's care records showed they needed some assistance to wash, and liked staff to dress them but wanted to choose which clothes to wear. People's views and any advanced decisions about resuscitation or end of life care were recorded in their care plan so staff were aware of them. Each person had a named care worker who was responsible for ensuring their care plans were reviewed regularly and for making sure they had enough toiletries and clothes.

People personal care needs were met, they looked well cared for, nails were clean and trimmed and people's clothes were ironed. Most people's rooms were personalised with their own furniture, books, CDs, as well as family photographs and mementoes.

At lunchtime people were able to eat independently, and some people had adapted cutlery to help them to do so. A person whose care plan said they were a vegetarian was given sweet and sour chicken for lunch. Staff said this

Requires Improvement

Is the service caring?

person often had salads which they preferred and they confirmed to us. They said, "Sometimes some of the girls give me a salad as they know I like and they're out of this world…they do sometimes ask me but not today." We explored this person's diet with staff further on the second day, as they were given meat again. Staff said the person did not eat pork but liked fish and chicken. When we checked their care records, in one section it said, 'I am a vegetarian' and in another section said, '(person) dislikes red meat, pork, likes salad and fish.' We were not able to establish whether or not this person was a vegetarian.

In the PIR, the provider said people had access to religious services and outlined further improvements planned included on-line staff training on death, dying and bereavement.

Requires Improvement

Is the service responsive?

Our findings

Although staff were friendly and supportive towards people, although care was often task based rather than meeting the individual needs of people at a time convenient for them.

The day was organised around routines of the home, rather than people's individual preferences and needs. For example, each person at the home had a designated 'bath day' per week, where they were offered a bath or shower and were offered a wash on other days. Staff also spoke about 'toileting' routines where people were escorted to the toilet or offered personal care at regular intervals during the day. Although no one said they were unhappy with these arrangements, they did not reflect people's individual preferences.

On the first day of the inspection, staff did not have time to engage with people in any activity or conversation. When we spoke with people they were keen to have a conversation. One person said they had tried being in the lounge and the dining room but said no-one talked to them and they said the activities offered were not to their liking. On the second day we visited, there was classical music playing in the lounge which one person was obviously enjoying and another was not. They said, "It drives me mad after a while, it's been going on for hours."

One person said that whilst staff did their best, the worst problem was "the boredom" and the best thing about the home was "getting out of it" each week. Another person said, "There is not much to do." A relative said, "Dad is bored but what more can be done?" Health professionals also commented about the lack of stimulation for people. One said, "A lot of people are just sitting around".

The home had one large communal lounge area situated centrally in the home, where up to 12 people gathered during the morning. Although there was music playing, and some people had newspapers or books open, most people were just sitting, looking passive or withdrawn, dozing, or looking around. Because of the location of the lounge, staff were constantly going through the lounge to reach other parts of the home. Staff that entered the room were cheerful and friendly, and we did not see anyone in distress or calling for attention. However, most of the time staff were busy on their way to another part of the home or with assisting people to mobilise. This meant interactions with people were very brief.

Although care records included information about people's interests and hobbies, we could not find evidence that people were supported with them. We asked the registered manager about how people were consulted and involved in agreeing their preferred activities. They said people were very hard to engage and generally staff organised the activities and trips. In the lounge area there were books, board games and jigsaws which people could access independently if they were able and some people had a daily paper delivered. The registered manager told us about outings and entertainers such as musical entertainment, and some trips out to visit local attractions such as Powderham Castle and for coffee or lunch. The deputy manager had produced a newsletter called 'Sparkle', which included historical articles of interest to people. This also included word games they had identified to help people with memory difficulties. However, no further newsletters have been produced since in March 2015.

We found there was a lack of stimulation or meaningful activities for people. According to the activities programme, activities were offered five afternoons a week. However, staff said this was very dependent on staffing levels. Staff said, when they had time, they did word quizzes with people, played games, did knitting and offered people manicures and nail care. An external person did a regular exercise class which staff said was was popular. Minutes of a staff meeting on 26 June 2015 showed staff were instructed to provide activities in the afternoon for a maximum of an hour, which is a very limited provision.

Several men lived at the home but the activities programme did not offer much that men in particular might have appreciated. However, the service had a male volunteer who visited people regularly which several men enjoyed chatting to. One said the volunteer had a services background and they enjoyed chatting to them about areas of mutual interest. This had also got to know another person who lived at the home, and they sometimes went to their room for a chat. The February and April 2015 provider report highlighted feedback, from the May 'Mystery

Requires Improvement

Is the service responsive?

Shopper' visits, about people being sat around, not talking, although the July report was more positive. However, our observations showed activities were inconsistent, and the improvements were not sustained.

Some staff did not demonstrate an understanding that activities needed to be differentiated for people's different abilities and interests or that socialisation needed to be encouraged. For example, the second day we visited, two staff engaged more with people in the lounge during the afternoon, than we had seen on the first day. One staff member started having a chat with two people and another staff member was doing their nails. However, the people staff engaged with were those in the room most able to chat and interact with staff, whereas a number of other people in the room just looked on. A third person tried to join in the conversation on two occasions, but staff did not notice and eventually the person gave up trying to join in.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives confirmed they were involved in the assessment and review of their needs, although one relative said they didn't feel that involved in the person's care plan and would like staff at the home to communicate more with them about this. Review dates showed care records were reviewed regularly, although few changes were made. Some aspects of the providers' care records were not personalised to people's individual needs and preferences. For example, as part of the assessment process, the providers care records used a series of set statements about people's abilities and needs, and staff had to choose which best described the person. For example, in relation to a person's memory, staff had to choose between several statements, such as 'I have a fair memory', my memory is fair/poor, I make things up because my memory is poor' and several others.

Some records were not being completed contemporaneously. We tried to find a person's most recent weight, which staff said should be in their care records but was not. There was a folder entitled monthly weights on a shelf in the office but this had last been used to record weights in 2013, which staff confirmed this was no longer in use. The deputy manager found this information, and showed us a sheet of paper with a number of people's weights recorded. However, the page was not dated, although we were assured they were records of people's weights for July, as they had completed them. This meant people's monthly weights were not being documented contemporaneously in their care records. This increased the risk important information about people's weights would not being communicated to staff in a timely way to inform their care.

Where people's individual care needs were identified, care records were very brief, and were not very detailed about how to support them as an individual. For example, one person was a diabetic but had no specific care plan to instruct staff about their care in relation to this health need. Another person remained in their room, they were at risk of isolation and were reluctant to eat but they had no care plans about these needs. The lack of individualised care plans meant people were at risk of not having their care needs and preferences met. People's daily records were mainly about how their physical care needs were met but lacked detailed about their psychological and emotional wellbeing needs or any details about how they spent their day.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, staff knew people well and provided us with a lot more information about people's care than was documented in their care records. The registered manager was aware of the limitations of the current care records and told us about the planned introduction of electronic care records, which would be more personalised.

The provider had a formal complaints policy and an leaflet which gave people information about how to complain. It included details about how people could raise concerns outside of the home, if they remained dissatisfied with how the home had responded to their concerns. People and relatives said they felt happy to raise any concerns with the deputy manager or registered manager and were confident that action was taken in response. Two people said they had a main care worker, known as a keyworker who they could raise concerns with, other people said they'd go to any member of the care staff. One relative had previously contacted the Care Quality Commission who were unhappy with the care of their relative, that stayed at the home for a brief period but has since moved to another home.

A complaint log was kept, which showed three concerns had been raised with the provider, two of which we were previously aware of, but no formal written complaints were

Requires Improvement

Is the service responsive?

received. The information showed action had been taken in response to all three concerns. For example, in response to a relative's feedback about their relatives care and room, a daily checklist had been introduced. This meant staff documented to confirm when personal care had been carried out and undertook daily room checks to ensure they were clean and replenished.

During a provider visit, the provider's representative suggested a comments and concerns book should be kept to encourage people and relatives to give feedback and suggestions, similar to those kept in other homes within the group. However, they commented the registered manager 'did not appear receptive to the idea.' When we asked about this, the registered manager explained people at the home were hard to engage in this way. For example, although they held residents meetings, people said they were happy with the care, but didn't usually come up with any suggestions, so they usually ended up organising things on their behalf.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager. Since the departure of the previous registered manager in 2013, there have been several changes of leadership. In February 2015, a director in the company became the registered manager. These management arrangements were interim, and a new manager was being recruited.

Feedback from people, relatives and visiting professionals showed organisation and leadership at the home was inconsistent. One relative said, "Some days are organised, other days less so." Health and social care professionals identified the need for more permanent management and leadership arrangements at the home as an area for improvement. This was because they felt there was a lack of direction from management .

On the first day of the inspection at 0945, the service seemed a bit chaotic because the deputy manager was working in the kitchen for part of the day because of staffing shortages. The registered manager worked at the home Monday to Thursday, and was primarily office based. They registered manager was visible in the home both afternoons talking to people, relatives and supervising staff. Most staff said they found the registered manager approachable, and supportive. Staff had delegated roles and responsibilities, for example one staff member was responsible for auditing medicines and another for undertaking people's initial assessments.

Staff said they worked together well as a team. One staff said, " I like it here…I like all the people and I'm happy here." However, some staff spoke about a long working hour's culture and expectations staff would work additional hours to cover vacancies, staff sickness and annual leave. This was supported by the staff rotas we looked at and because several staff were working up to 60 hours a week.

Staff said they did not have any official breaks, despite working long hours. They could grab a drink or food on the go but said they were not encouraged to sit down and take a break during their shift. There was no overlap between shifts but staff contracts of employment showed staff were contractually obliged to report for duty 10 minutes before their shift started, so they could receive staff handover. This meant staff coming on shift were not being paid during the staff handover period. These working arrangements did not value staff and were not in accordance with the requirements of the European Working Time Directive. Although staff can choose to opt of these arrangements, and some had done so, other staff felt the provider expected them to opt out, although they did not wish to do so.

The provider had a range of quality monitoring systems, but these were not fully effective. This was because several of the issues we identified at the inspection had been repeatedly identified in the provider visit reports, including three of the breaches of regulations found. These issues had not been addressed and those risks remained.

The quality monitoring systems included audits of medicines and of care records, regular meetings with people, and staff. The registered manager said they monitored cleanliness and checked staff were following the uniform policy and addressed any issues as they found them, although these checks were not recorded. The provider also sought feedback on the home through "Mystery Shopper" visits undertaken by an external company. A representative of the provider undertook detailed quality monitoring visits every other month and produced detailed reports.

We looked at the provider's quality monitoring visit reports for February, April and July 2015. These reports highlighted delays and disagreements as well as reluctance to take remedial action in areas where areas for improvement were highlighted. For example in relation to staffing levels and recruiting a cleaner, and providing more individualised care, activities and stimulation for people.

The systems for maintaining and updating care records needed to be improved. This was because care plans lacked detail about people's individual care needs and some records were not fully completed. The provider's quality monitoring reports repeatedly highlighted that little progress being made in relation to incomplete care records. The reports recommended the registered manager oversaw audits to ensure the findings and recommendations were carried out.

Some records relating to the home were not accurately maintained. Staff rotas were not accurate and did not document accurately all the hours staff worked at the home, such as between eight and eleven pm at night and between six and eight in the morning.

The provider had a reporting system whereby registered manager were expected to report information regularly

Requires Improvement

Is the service well-led?

about the home such as bed occupancy, accidents/ incidents and complaints. However, the registered manager said currently they did not complete their returns as they did not have the computer skills. This meant the provider was not receiving regular reports that might highlight risks that needed addressing.

The provider had documentation for staff to use to record regular checks on people at high risk of falling, known as an 'Intentional rounding form.' When we asked the registered manager about why this was not being used for a person at risk of falling, they were not aware of this documentation, so staff were not using it.

The provider had a system for staff to undertake and record monthly health and safety checks of all areas of the home and to monitor accident/incident trends in the home. However, this system was last used at the end of 2013. When we showed the registered manager and deputy manager this folder, and asked about these checks, neither were aware of this system and were not using it.

The provider visit reports showed there were concerns about staffing and staff morale related to a long term vacancy for a cleaner not being filled, and insufficient action being taken to address this. The July 2015 provider visit report it said, 'We are exploiting a lot of good will and/ or creating an atmosphere of fear amongst the care team who are not speaking up but are not happy and not coping.' When we checked what happened in response to the provider visit reports, they was no process in place to develop an action plan in response. This showed the provider's quality monitoring systems were not effective as insufficient action was taken in response.

There is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider monitoring reports also showed some environmental improvements had taken place, for example, two new boilers had been installed at the home and repair work was completed on some of the windows. The 'Mystery Shopper' reports also highlighted some positive feedback. For example, the April report commented on progress in developing an activities programme for the home and the home being well kept, clean and tidy.

The Care Quality Commission did not receive any notifications about serious injuries to people or about safeguarding concerns since the last inspection. We checked with the registered manager whether this was accurate and they confirmed there hadn't been any safeguarding concerns or injuries that should have been notified.

The service had regular residents meetings, and the minutes of the most recent meeting showed eight people attended and the menu, meal times and trips were discussed. People were invited to raise any issues or concerns and confirmed they did not have any issues to raise.

The service had regular staff meetings and meeting minutes on 26 June 2015 showed staff discussed trips and outings for people living and organising a summer fete. They also showed the registered manager discussed staff attendance at training and staff were offered the opportunity to raise any issues, and none were raised.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure there were sufficient numbers of staff to meet people's care and treatment needs at all times. This is a breach of regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were confusing and contradictory. This meant it was not clear whether or not individuals had the ability to make day to day decisions, or give their consent. This is a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People's care was not personalised for them but was organised around tasks which needed to be completed. People lacked stimulation and some people were bored. Activities were limited and did not support people's individual interests and preferences. This is a breach of regulation 9 (1) (a) and (b).

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had failed to adequately assess, monitor and improve the quality and safety of the services provided. Where risks and concerns were identified, they failed to take action in a timely way to improve systems and mitigate risks to the health, safety and welfare of people. This is a breach of regulation 17 (1) (2) (a) (c) (e) and (f).