Laudcare Limited

Blackwell Vale Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 26 and 28 September, 2 and 11 October 2017. The visit on the 26 September was unannounced. This meant that the provider and staff did not know we would be visiting. Subsequent visits were announced.

Blackwell Vale Care Home is a 51-bed home providing residential, nursing and dementia care. There were 49 people living at the home at the time of the inspection.

A registered manager was in post and our records showed she had been registered with the Care Quality Commission [CQC] since 2010. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found concerns with the safety and security of the premises. We accessed the top floor of the building via an open fire door early in the morning. We also found a number of hazardous items and equipment that were accessible to people throughout the home, including those living with dementia.

Infection control was poor and we found dirty bedding and equipment which was so heavily contaminated it had to be cleaned or discarded during our inspection. Bathrooms and toilets were not fit for purpose. A number were used as storage, or were damaged and unable to be used. Toilets were positioned on raised plinths which were damaged, unsightly and were not impermeable to urine meaning they could not be effectively cleaned. Some posed a risk to people due to sharp edges.

Personal Emergency Evacuation Plans (PEEPS) were in place for people who had died, and a number were missing for people that had moved into the home. These were updated during our inspection. Individual risks to people were assessed, but care plans developed to mitigate risks were not always followed; in relation to choking for example.

We found medicines were not safely managed. Records were not accurately maintained and we found a medicine error following a review of stock levels. Guidance was not fully in place to describe how medicines given as and when required should be administered. Prescribed medicines were not always made available to people in a timely manner. The registered manager carried out a full audit of all medicines following the concerns we raised and found some further discrepancies which they put plans in place to correct.

Records did not support that staff had received the training they required to carry out their role safely. Nursing competency and clinical training records were not up to date and could not evidence that nursing skills were being maintained and monitored. It was difficult to ascertain from training records, the percentages of staff that had received up to date training. Staff told us they received regular supervision and that they felt well supported.

Sufficient numbers of suitably qualified staff were not always deployed effectively in the home. The provider was having difficulty in covering shifts due to staff absence at short notice particularly at the weekends.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes.

People were not always supported to have choice and control of their lives. Records did not demonstrate that staff supported them in the least restrictive way possible and contained conflicting information. The policies and systems in the service did not always support this practice.

There were complaints about the quality and variety of food provided and meetings were taking place to address this at the time of the inspection. We found kitchen staff had not been trained in the preparation of special meals including pureed diets, and meals were provided which contained lumps and posed a choking risk to people. Training was provided soon after we raised this concern.

We observed care that was kind and considerate and most people and relatives we spoke with told us they were happy with the care provided. We were told, and observed documentation that demonstrated, there had been a prolonged period of staff unrest on the upstairs Nightingale and Chadwick dementia care units. This had resulted in staff refusing to work with others and even sickness and stress. We were advised that this did not impact upon people who used the service but we judged that although this behaviour was caused by a small number of staff, the impact was widespread and affected the smooth operation of the service.

A complaints procedure was in place and we found a number of complaints had been made including relating to the manner and attitude of staff. These had not all been thoroughly investigated and we referred some of these complaints to the local authority safeguarding adults team. Following our inspection the senior management team reviewed all complaints and in some cases took action to look into individual concerns in more detail.

Care plans were in place for each person but the information in plans varied in quality and detail. Some care plans were detailed and person centred, others contained inaccurate information and did not reflect care as it was being delivered at the time of the inspection. Others contained contradictory information so it was difficult to ascertain which was the correct version.

A range of activities were available and we observed group and individual activities. There were mixed views about the range available to ensure people had opportunities to engage in meaningful activities of their choice and to go outside. We were told by some people however, that activities had improved of late. Staff had worked hard to create areas of interest in the home such as a garden room. A sensory room was also available.

An effective system was not in place to monitor the quality and safety of the service and records for not all up to date and accurately maintained. The registered manager and provider had not picked up all of the concerns we identified during this inspection.

Following the inspection, we wrote to the provider to request a detailed improvement plan which stated what action they had taken or planned to take to address the concerns and shortfalls identified during the inspection.

We referred all of our concerns about the service to Cumbria County Council and following our inspection, the local authority had placed the home into 'organisational safeguarding'. This meant that the local authority was monitoring the home closely.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found six breaches of the Health and Social Care Act 2008. These related to safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, receiving and acting on complaints, good governance and staffing.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

We found concerns of a safeguarding nature had not all been reported or dealt with in accordance with the provider's safeguarding policy.

We found a number of environmental hazards which exposed people to the risk of harm which had not been picked up through routine audits on the safety of the premises.

Medicines were not managed safely. We found errors in the administration and recording of medicines.

Individual risks to people were assessed but care plans in place to mitigate these risks were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

There were concerns with the quality and safety of the food provided. Pureed meals contained lumps which exposed people to the risk of choking.

Staff did not always have the skills necessary to carry out their roles competently including the clinical skills of some nurses and catering staff training also contained gaps.

Records did not always demonstrate the service was operating within the principles of the Mental Capacity Act [MCA].

Is the service caring?

Requires Improvement

The service was not always caring.

Due to the concerns identified during the inspection, we found that the provider had not always ensured that people received a high quality, caring service.

We were made aware of and observed a number of kind and attentive interactions with people. People and relatives spoke

highly of individual staff members and told us they were kind.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Complaints had not always been dealt with in line with the provider's own complaints procedure and records of action taken lacked detail.

Care plans varied in quality and detail. Some contained gaps or conflicting information.

There were mixed views about the activities available, we observed a number of people enjoying activities during our inspection and saw plans in place for the future. Some people and staff said they would like to go out more and for people nursed in bed to have access to more activities.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality and safety of the service had not identified the concerns we found regarding environmental safety, infection control, medicines management, safeguarding, and staffing.

Morale was low amongst some staff members in the home due to continued unrest and disputes between a small number of staff. Attempts at addressing these had not been effective.

Staff and relatives told us the manager was friendly and approachable.

Blackwell Vale Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 28 September and 2 and 11 October 2017. The first day of the inspection was unannounced. This meant the provider did not know we were coming.

The inspection was carried out by two adult social care inspectors and a pharmacist.

Prior to the inspection we reviewed all of the information we held about Blackwell Vale including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We also spoke with Cumbria County Council safeguarding and commissioning team. We took the information they provided into account when planning our inspection.

During the inspection we spoke with ten people who used the service, and six relatives. We also spoke with staff including the registered manager, deputy manager, regional manager, two nurses, one Care Home Advanced Practitioner [CHAP], nine care staff, an activities coordinator, two domestic staff and two cooks. We also spoke with a community nurse and GP. We checked six staff files, and eight people's care plans. We also looked at a variety or records related to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

On the first day of the inspection we were able to access the building via a fire door and stairs to the first floor, where a push button enabled entry to the dementia unit. This meant the building was not secure and could have been accessed by un-vetted persons. We spoke with the registered manager and regional manager about this and they instructed staff and took steps to ensure the door would no longer be routinely used by staff.

Storage rooms were accessible to people. The policy of the provider was that these areas should be inaccessible to people using the service. We found a kitchen storage room was unlocked, despite having a key pad lock for use by staff, which had been disabled. The regional manager confirmed this room should be locked. We found a number of bathrooms were being used for storage of equipment. These were cluttered and potentially hazardous. They were accessible on the first two days of the inspection.

An inspection of communal areas and bedrooms in the Chadwick and Nightingale dementia care units found that people had unrestricted access to a range of potentially hazardous substances including urine neutraliser, alcohol, denture cleaning tablets and 'Thick and Easy' food thickener. Accidental ingestion of denture cleaning tablets can result in airway obstruction and oesophageal ulceration. A patient safety alert was issued by NHS England in 2015 highlighting the risk of asphyxiation from the accidental ingestion of food and fluid thickening powder. This exposed people to the serious risk of harm by way of aspiration and choking.

We found a pair of craft scissors in a TV cabinet in the lounge. We were told that scissors and other sharp objects were normally inaccessible to people with dementia to ensure they are appropriately supervised while using them. We gave these to the staff member present to store safely and informed the registered manager. Alcohol was also found in an unlocked cupboard on the ground floor. The provider confirmed that people with cognitive impairment also lived on the ground floor therefore alcohol should have been locked away.

A chest of drawers was immediately removed by the deputy manager when we pointed out the broken drawer handle which meant a very sharp disc of metal was protruding at ankle height. This had not been picked up by care or maintenance staff or the registered manager during routine environmental audits.

We reviewed Personal Emergency Evacuation Plans (PEEPs). PEEPs outline the level of support people need in the event of an emergency evacuation, including mobility needs and ability to understand instructions. We found eight PEEPs belonging to people who had died. We also found that PEEPs were not in place for seven people who had been admitted to the service. These were updated and all other PEEPs reviewed by the second day of the inspection to ensure they were up to date.

Infection control procedures were not always followed. We found a mattress and pillows belonging to one person which were very heavily contaminated with urine. Clean linen had been placed over the mattress and pillows by staff who had failed to recognise the risks to the health and dignity of the person sleeping in a

bed soaked in stale urine. The mattress and pillows were deemed so heavily contaminated they were disposed of and replaced during the inspection. This meant the provider did not meet the standards outlined in the Code of Practice for all providers of healthcare and adult social care on the prevention of infections under the Health and Social Care Act 2008.

The design and condition of bathrooms meant they could not be hygienically maintained as toilets were built on raised plinths which were damaged or unsealed therefore not impermeable to urine. We found the underneath of a bath seat heavily encrusted with dirt and hair. This was immediately cleaned when we showed the registered and regional manager who confirmed it did not meet satisfactory hygiene standards expected by the provider.

We checked a bed that had been made by staff and found bedding to be marked with what we determined to be faeces. We showed this to the registered manager who agreed the bed was dirty and it was immediately changed. Bed rail bumpers and crash mats used at the side of people's beds in case of falls were also dirty. We found two beds with mattresses which were too short leaving a gap at the headboard meaning there was a risk of entrapment. The provider sought immediate advice from the Health and Safety Executive and foam wedges were put in place at the end of beds to close the gap until mattress extenders were available. These were ordered immediately.

By the second day of the inspection, an audit of all beds had been carried out. Equipment had been washed and damaged items had been disposed of.

We found that appropriate arrangements for the safe administration and recording of medicines were not in place. Records for medicines prescribed topically such as lotions and creams were incomplete. We were unable to determine whether creams had been applied as prescribed. One person was receiving a variable dose of medicine and we found they had received the wrong dose. The medicine was one which could cause harm if administered incorrectly. We told the registered manager and regional manager about this and steps were taken to reduce the risks of further errors in administering this medicine. Instructions for some people receiving medicines as and when prescribed were missing. This information is important to ensure staff are aware of the circumstances under which these medicines should be given.

A bottle of liquid medicine for one person had been dropped and therefore destroyed. A replacement bottle was not ordered in a timely manner which meant a delay of a week for one person in receiving their treatment. Following our feedback the registered manager completed a full audit of medicines and found other areas of non-compliance with the home's medicines procedure, including the wrong dose being administered to two people [less than prescribed] and missing instructions for as required medicines. The deputy manager confirmed staff administering medicines received an extra supervision session to ensure they were following the correct procedures and the missing paperwork was replaced.

Individual risk assessments had been carried out, for example in relation to falls and choking. Care plans were in place to mitigate these risks but were not always followed. For example, people assessed as being at high risk of choking had a plan in place which described the consistency of food they were able to eat. Where people were prescribed pureed meals, we found they were not always suitable as they had not been prepared correctly so contained lumps. This meant people were at risk of choking on these meals.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safe care and treatment.

We received information of concern prior to our inspection relating to the care of people living in Blackwell

Vale including how people were spoken to by staff, in particular in the Nightingale and Chadwick units. We did not observe any staff speaking in an inappropriate manner during the inspection. There had, however, been previous concerns raised about the manner and attitude of some staff. We found a number of complaints that had been made of a similar nature. These had not all been referred to the local authority safeguarding adults team, and we judged they had not been robustly investigated in line with the provider's safeguarding procedures.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Safeguarding people from the risk of abuse and improper treatment.

We found there were suitable numbers of staff on duty during our inspection. We were told, however, that there were difficulties with covering the home at weekends in particular due to frequent staff absence at short notice. Staff told us this happened on a regular basis. One staff member said, "It is hard to cover when people go off at the weekend. Who wants to come in and cover on their weekend off?"

Staff told us they were aware of the procedure to follow in the event of safeguarding concerns. None of the staff we spoke with had seen anything to concern them and said people were treated well. We passed information about these complaints and our concerns for people's safety to the local authority safeguarding and commissioning team. The service was subsequently placed into 'organisational' safeguarding. This means the service is being closely monitored and supported by the local authority.

We checked staff rotas and found the home was not always staffed in accordance with the numbers we were provided with during the inspection. Staff told us they thought there should be more staff on duty. They felt that additional staff were required in order to take people out in the garden or further afield. One staff member said, "When we have surplus staff on through the week we have managed to get people outside." Another said, "It would be nice to have enough staff to take people out; even in the garden. Staff need to come in on their days off for day trips." A visiting professional told us they thought staff deployment was an issue due to the staff taking breaks together.

We asked the registered manager for assurance that shifts were covered for the weekend following our inspection and were told the home was fully staffed. Two people called in sick at the weekend which left the home short staffed. Staff told us this was not unusual.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Staffing.

Following our feedback the provider put in place an absence monitoring system to ensure they were fully aware of any staffing concerns and to monitor that correct procedures for managing staff absence were followed.

We checked staff recruitment records and found one staff member did not have a recent check by the Disclosure and Barring Service [DBS] and last had a criminal records check in 2004. We spoke with the registered manager about this who explained the check had been missed while updating recruitment records. Immediate steps were taken to obtain an updated check. The DBS checks the suitability of people to work with vulnerable adults which helps employers to make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

We were made aware of a number of concerns regarding the quality and variety of meals. People told us they found menus repetitive. One person said, "Meals are tedious. There are too many baked beans. I am sick of the sight of beans." People also complained about supper which they said was the same every day. Staff also told us they had concerns about the quality and variety of food, and we read a number of comments referencing the food in a feedback book in main reception. Comments from people and staff included, "Food varies day to day. Sometimes it is good, at others it is not so good. There is a lack of choice; soft diets look like mush on a plate. It is unappetising" and "Food could be better. Soft diets look boring and the same with lots of mash. There is not always enough to give people second helpings; if it's there I give it to people."

We observed meals and noted that a meal which included pureed sardines looked unappetising and was surrounded by watery liquid. Pureed meals given to people who were at risk of choking contained lumps and staff told us they were not always safe to give to people. One staff member said, "Sometimes pureed meals are a bit lumpy. We are all aware there are lumps so we try to work around them rather than feed to a resident that's going to choke on them." Another staff member told us, "If the food is lumpy I don't give it or put milk in it. I sometimes give people two puddings instead."

We checked and found no evidence that cooks had received training in fortifying food for people at risk of losing weight, or in preparing special diets such as pureed meals for people experiencing dysphagia (swallowing difficulties). National descriptors were not always used to describe the consistency of pureed meals as outlined by the NHS National Patient Safety Agency 2011 such as 'category B thin puree dysphagia diet', or 'category C thick puree diet'. Kitchen staff told us care staff sometimes returned food they felt was too runny, while others would return food as they felt it was too thick for the same people. Staff were therefore giving people food of varying consistencies and care plans did not clearly outline which was correct.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Meeting nutritional and hydration needs.

We spoke with the registered manager and regional manager who checked the safety of all pureed meals to ensure they did not contain lumps prior to training being provided to kitchen within two days of our feedback. They told us care plans would also be amended to ensure they contained accurate information for staff to follow. We observed staff supporting people appropriately during mealtimes. The registered manager told us meetings had taken place with the company contracted to provide meals in order to review choices and satisfaction with meals in the home.

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 authorisation 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. We found that the manager had submitted DoLS applications in line with legal requirements. There was a delay in the authorisation of applications for people which was beyond the control of the provider.

Mental capacity assessments had been carried out but records contained conflicting information about whether people had capacity to make decisions. In one record a person was described as having capacity to make decisions but this was contradicted elsewhere in the record. Some people were receiving medicines crushed and mixed with food. Giving people medicine without their knowledge mixed in food or drinks is called covert medicine administration and is sometimes necessary in the best interests of people who may lack the capacity to understand risks associated with refusing to take them. Care records did not always demonstrate that this was a planned intervention agreed in people's best interests or whether this was due to swallowing difficulties as opposed to refusal to accept the medicine. We spoke with the registered manager about this and they advised us that the plans we identified would be updated with clearer information.

Records of nurse competencies were not satisfactorily maintained to demonstrate they were clinically up to date. End of life care was provided in the service although nursing staff were unable to set up a syringe driver which is often needed at this stage. Syringe drivers help relieve symptoms such as pain and distress through delivering a flow of injected medication continuously under the skin. A GP told us they found nursing staff were delivering such medicines via subcutaneous injections as there was no one in the premises able to set up the driver. They said once they had decided this should be put in place they expected it to be operational within four hours and did not find it acceptable that delays should occur in a nursing home. We spoke with the registered manager who showed us competency assessments she was going to introduce to ensure that nursing staff were competent in a range of clinical skills to meet the needs of people. Only two staff were competent to take blood [venepuncture]. The deputy manager told us that this was being addressed. We saw that tissue viability [skin care] training had been arranged.

Nursing staff had received support with 'Revalidation', the new process by which nurses demonstrate they remain up to date and eligible to remain on the professional register. One nurse told us, "We did have the CLIC people come in last year to help the nurses with revalidation and we did training like verification of death and diabetes. I would love to do my venepuncture training…I have done supra pubic catheter insertion and so I can reinsert PEGs." CLIC is the Cumbria (Health and Social Care) Learning and Improvement Collaborative initiative. Percutaneous Endoscopic Gastrostomy (PEG) is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines.

Training was provided to staff in subjects considered mandatory by the provider. These included training in moving and handling, safeguarding, basic life support and fire safety. We were provided with a list of staff and training they had received. Some training was overdue and the registered manager told us plans were in place for training to be brought up to date. We observed staff completing training on a computer tablet during our inspection. Staff told us they received regular training and said they felt well supported. The home had just received dementia care accreditation from the company having completed the provider's dementia care framework.

Comments from staff included, "I've had all my training. We've all just done training in the dementia framework" and "Training is good, I'm doing my NVQ 3 [National Diploma in Health and Social Care] and I've just got 18% left to do and I do training with the Care Home Education and Support Service [CHESS] team. It's a 10 week course and each week there is a different topic. Last week we learnt about different parts of the brain and how they affect your functioning and the week before that we learnt about distressed reaction. It's good and I can bring all that back to work." Staff told us and records confirmed they received supervision on a regular basis.

The registered manager told us about the Dementia Care Framework (DCF) accreditation, they said, "We've just passed the Dementia Care Framework which took 18 weeks and we had a big party. [Name of celebrity] came from the Antiques Roadshow. We gave all the staff certificates and a badge and a box of chocolates so it's giving them something." We spoke with a DCF trainer who told us the modules staff completed consisted of gaining an greater understanding of dementia including the experiences of people living with dementia and how best to communicate with and support people. During our inspection we spoke with a Care Home Assistant Practitioner (CHAP) who demonstrated a good knowledge of dementia and associated acute disorders such as delirium.

We observed that not all areas of the home met best practice guidance in relation to supportive design for people living with dementia. This included insufficient toilet signage; some doors in the home said 'Fire door keep shut' when they were in fact toilets. Contrasting handrails and toilet seats were not provided in all bathrooms although we were told this will be considered as the bathrooms are refurbished in the near future. Flooring on the ground floor in particular did not meet best practice guidance in that there were contrasting light and dark areas of flooring including at door thresholds which some people living with dementia can perceive as a void or step. We were advised that the main focus of accreditation was on the first floor dementia care unit and that other works were in progress to enhance the dementia friendly design of the building.

Due to people living with cognitive impairment also accessing and living on the ground floor, we recommend that best practice guidance in this area is followed in relation to supportive design for people living with dementia throughout the home.

Staff had worked hard to develop an upstairs garden room which contained deck chairs, plants and artificial grass. There were outdoor sounds to add to the sensory experience and it provided an area for people to relax. We also saw people watering the plants. A sensory room was also available which contained equipment designed to provide sensory stimulation or relaxation.

Requires Improvement

Is the service caring?

Our findings

People told us they felt well cared for. Comments included, "Yes, I'm happy here. Do you see that lady that went out, wasn't she lovely? We smile at each other and laugh, it's nice," "Staff are kindly. I'm quite happy here. I like the way they treat people; nice manners," and "They look after me and I'm thankful for that." A relative told us, "I am very impressed. Staff care for my relation beyond expectations. I can leave here and have a lot lifted off my mind." Another relative told us, "Staff are all great, never come across anyone we are not happy with. They are quite dedicated." A visiting professional told us, "People appear clean and tidy and well cared for and staff are friendly and approachable."

Most staff told us they were very happy working in the home, and we were given examples of where staff had shown real kindness and concern for people. One staff member told us, "It's a rewarding job. You do get attached to people. There is a lady that loves cats and I told her I had a kitten duvet and I showed her it on my phone and she loved it so I went to buy her one." Other comments from staff included, "The residents and staff are why I love my job. I love talking to them and hearing their histories and all about their families and when they were growing up and also having a giggle with them. We have a right old giggle some days" and, "I love it. I absolutely love my job. Genuinely, it's one of the only jobs I've ever had where I enjoy coming to work." We read in care records that a staff member had brought their dog in to the home to cheer a person up who had suffered a recent bereavement. They recorded they wanted to make the person smile and that they had enjoyed cuddling the dog.

We observed staff responding kindly to people during the inspection and maintaining their privacy and dignity. Staff knocked on people's doors before entering bedrooms and we observed one staff member ask if they could adjust a person's clothing as their abdomen had become exposed. They asked, "Is it okay if I tuck you in a little bit?" Labelling of people's names on clothing and socks was not always discreet and could compromise dignity.

We recommend that staff monitor this to ensure dignity is maintained.

Despite observing a number of examples of kind and compassionate care, we found there had been a prolonged period of unrest and relationship difficulties with a small number of staff, predominantly on the upper floor Chadwick and Nightingale units. This had resulted in some staff feeling unable to work with others and had impacted significantly upon the staff team. They told us, "There is a problem with back biting and gossiping and divisions between staff." Another staff member said, "There are a few issues with staff refusing to work with other staff members. At one point I didn't want to be here anymore." Staff on the ground floor told us the two floors were very separate and said, "Never the twain shall meet."

We spoke with the registered manager who told us there had been a difficult period with the staff group which involved a minority of staff and they were aware this was impacting adversely on the wider staff team. We were concerned about the impact poor relationships between staff could have on people living with dementia in the Chadwick and Nightingale units; particularly as we were told some staff were unable to be caring and professional towards each other in the workplace. We were advised by managers and staff that

this behaviour was never evident while staff were working with people. We raised these concerns with the senior management team who advised although there had been some work undertaken to address these issues, a full formal investigation into these concerns would commence.

End of life care was provided in the home where it was the preference of people to stay there and staff received training and support from other professionals as required to achieve this. A GP told us the care that staff provided to people at the end of their lives was good with their only concern being the ability of nurses to set up the pain relief syringe driver in a timely manner. Otherwise they felt people were well supported by care staff at the end of their lives.

There was no one accessing any formal advocacy service at the time of the inspection but staff told us they knew how to access this service for people should it be required. An advocate provides independent support to people to make and share decisions.

Requires Improvement

Is the service responsive?

Our findings

We reviewed complaints received by the provider and found action taken was not always suitably robust. Records did not contain satisfactory detail to evidence action taken to address the concerns, and senior managers were not made fully aware of all complaints received which included a number relating to the manner and attitude of staff. Complaints had not been monitored effectively for patterns and trends which we had identified. We passed our concerns to the regional manager who told us they would arrange to review complaints records. We were advised following our inspection that further action had been taken by the provider to ensure the correct procedures were followed having identified the response to some complaints had not been in line with the provider's complaints procedure.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Receiving and acting on complaints.

Care plans were in place which varied in quality and detail. Some contained sufficient detail to guide staff in how to respond to people's care needs. Other care plans required more detail, for example, a plan relating to the continence needs of one person stated, 'Use appropriate aids' but did not say which type of continence aids should be used.

An accurate record of wounds was not fully in place. Some wounds were recorded on a white board, some in a daily flash meetings and the manager completed a monthly wound analysis, however there was no main overview to ensure that all wounds were identified and dressings were carried out in a timely manner. Records did not always demonstrate dressings had been carried out as planned. One person's wound management plan stated staff should change the dressing at least once a week. There were gaps in records which meant dressings did not appear to have been changed in line with the frequency outlined in the plan.

Dressing reviews did not always state the size or appearance of the wound to ascertain if there was any improvement or deterioration. Types of dressings in use did not always correspond with the initial wound management plan which meant records were not always updated or sufficiently clear. Photographs were not consistently taken to enable close monitoring of the wound. We spoke with the registered and deputy manager about wound care plans and they told us that training was already planned which would support staff to plan and implement wound care more effectively. It was confirmed this training had been completed following the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

We reviewed records held in people's bedrooms on the morning of the first day of our inspection and found records of positional changes, food and fluids taken and bed rail checks had been completed.

We received mixed views about the responsiveness of the service. Some people told us they felt their needs were well responded to, and relatives told us staff kept them well informed of their relation's care needs. A

relative told us, "They [staff] write things down in the binder so we know exactly what is going on." Other people told us they did not always have a bath or shower as often as they would like. One person told us, "I have a bath once a week. I would like to have more, but they don't have enough staff or bathrooms. At home I was used to having a shower every day." Another person said, "I'd sometimes like to have a bath but I don't like to ask because the girls are busy."

We spoke with the registered and regional managers about the availability of bathrooms. A review of all bathrooms was carried out by the provider's maintenance staff on the second day of the inspection. They told us some bathrooms were surplus to requirements and would be de-commissioned and a plan was being developed to refurbish the remaining bathroom areas. We found there were sufficient numbers of assisted bathrooms available for use on each floor which meant people with limited mobility could be bathed safely. We were not aware of any serious concerns relating to personal hygiene and people we spoke with appeared to have had their personal care needs met.

We recommend in light of the mixed feedback we received that people's satisfaction regarding opportunities for support to shower and bathe remains under review.

A range of activities were available. Activities staff were observed supporting people to take part in activities in groups and individually during the inspection depending on their needs. A number of plans were displayed such as forthcoming Halloween activities. Sensory activities were available for people including scents to support reminiscence including engine oil, and car air freshener for example. A staff member told us, "One person is a little forgetful and so we look through old photographs and everything comes back to her." We observed another person who was enjoying being busy and sweeping the floor in the Nightingale unit. We read in one person's care record that staff had noticed they appeared to get on particularly well with another person living in the home. They suggested that they should be supported to spend time together. This meant staff were aware of the ways in which they could help people to form new friendships and help to prevent loneliness or social isolation.

Some people and staff said they thought the range of activities could be improved, particularly for people who were nursed in bed and more trips outside the home.

We recommend satisfaction with activities is monitored in light of the mixed feedback we received.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post who had been registered with CQC since 2010. They were supported by a deputy manager who was also a registered general nurse. A regional manager also visited the service on a regular basis. Staff and relatives told us the registered manager was friendly and approachable.

We found a number of shortfalls in the service which had not been picked up through the provider's own quality and safety monitoring systems. The provider had failed to identify the concerns we found regarding environmental safety, infection control, medicines management, safeguarding, and staffing. Governance systems in place were not always followed and this meant people were not protected from the risk of unsafe care and treatment. The volume of omissions was concerning and highlighted a clear failure in governance systems.

We identified shortfalls in the maintenance of records of people using the service and staff. Care plans contained gaps or conflicting information, including relating to the MCA, nutritional needs, and care of wounds. Medicines records were not accurately maintained. Records of complaints made by people and relatives were not sufficiently detailed. There were gaps in staff recruitment and training records including nursing clinical competencies.

Morale within the home fluctuated. Staff told us they felt the prolonged unrest on the upper floor impacted upon the atmosphere in the service. One staff member told us, "Downstairs there's a lovely atmosphere. I always work downstairs, but upstairs, it's horrible. Some of the staff have been known to phone in sick. You can tell there is an atmosphere. Management are aware and they say they are dealing with it, but nothing seems to have changed." This was repeated by other staff who told us that the issue was continuing and in their view was not being managed effectively. People living with dementia are sensitive to the interactions between staff and the social environment in which they live. Despite assurances they were not aware of this, we judged that this prolonged disharmony exposed people living in the home to the risk of psychological ill-being and it was having an impact upon staff morale.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

The registered manager, deputy and regional manager were proactive in dealing with our concerns as they arose, and following our feedback the provider undertook immediate investigations into some of the issues we had raised. They assured us of their commitment to making the necessary improvements.

The views of people and relatives were obtained by the provider by way of an annual survey. A comments book was also kept in the foyer in the home for people relatives and staff to share their views.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people had not always been assessed and action had not always been taken to mitigate any such risks. Procedures were not always followed to ensure the safe and proper management of medicines or risks associated with the prevention control and spread of infection. Not all areas of the premises were safe for their intended use or used in a safe way. Regulation 12 (1)(2)(a)(b)(d)(g) (h).

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not fully protected from the risk of abuse because safeguarding procedures were not always followed. Regulation 13 (1)(2)(3).

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Nutritional needs were not fully met. Food was not

always available in suitable variety and quantity or safely prepared to meet the individual needs of people.

Regulation 14 (1)(2)(b)(4)(a)

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Appropriate action was not always taken in response to complaints received. Complaints were not monitored by the provider to identify trends or areas of risk to be identified. Regulation 16(1)(2)

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people and others. Records relating to people, staff and the management of the service were not always accurately maintained. Regulation 17(1)(2)(a)(b)(c)(d)(f)

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Regulation 18 (1)

The enforcement action we took:

We imposed a condition to suspend admissions and for the provider to assess the competency of the registered manager