Care Quality Commission

Roseberry Care Centres GB Limited

Dalewood View

Inspection report

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Date of inspection visit: 8 and 10 December 2016
Date of publication: 19/02/2016

Ratings

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

Overall summary

We carried out an inspection on 8 and 10 December 2015. This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The service was last inspected on 19 May 2015 and was not meeting the legal requirements of the regulations for person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staffing and fit and proper persons employed.

At our last inspection of May 2015 we found the service was in breach of six regulations. These related to; person centred care, safe care and treatment, safeguarding people from abuse, good governance, staffing and fit and proper persons employed. As a response to this, the provider sent an action plan of the steps they would take to meet the legal requirements of these regulations. We undertook this latest inspection to establish what progress the service had made to meet these requirements.

Dalewood View is a nursing home that provides care for up to 60 people. At the time of the inspection there were 31 people living at the service. The service has three

Summary of findings

floors; a lower ground floor where the service's activities room is based, the ground floor which is primarily for people requiring nursing care and the first floor which is primarily for people requiring residential care. At the time of the inspection there were fourteen people requiring nursing care on the first floor.

There was no registered manager in post at the time of the inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A new home manager had commenced employment the week of the inspection who was being supported by a regional support manager. The regional operations manager who had managed the service for a period of time was still involved with overseeing the service.

Although people we asked told us they felt safe, we found that care delivered, particularly to people in receipt of nursing care was not safe. Systems and processes to identify safeguarding concerns were not suitably robust to protect people. For example, we found little investigation into wounds and bruising people had sustained. The service did not have appropriate arrangements in place to manage medicines safely and we found a repeat of issues in regard to medicines that we had identified at our last inspection. Individual risks to people were not appropriately assessed and managed to maximise safety and the level of risk to people was not always clear due to conflicting information.

There was evidence in peoples care plans of involvement from other professionals such as doctors, opticians, and speech and language practitioners. Professionals we spoke with felt the service did not always accommodate people's needs. We found that people were not always supported by staff in accordance with their needs and the care provided was inconsistent.

Deployment of staff needed improvement at times as we saw instances where people who needed assistance to eat did not receive this. People and relatives commented that staff often changed which impacted on the continuity of care people received.

We found recruitment procedures were not effective as appropriate checks had not been undertaken to ensure the suitability of staff prior to commencing employment. Staff told us they received supervisions and felt supported but we found some shortfalls in the training staff received appropriate to their roles and responsibilities. Competence and skills of nursing staff was not effective to meet people's needs.

Consent was not always sought in accordance with the Mental Capacity Act 2005. There was evidence of some decisions being made in people's best interests but this was not consistently applied.

Although staff interactions were primarily positive and staff were polite and courteous, these interactions were mainly centred around tasks. People and their relatives gave mixed comments about staff and how they were cared for.

There was an activities worker in post and we saw activities take place however there was limited stimulation available for people who were not able to attend these. 'Relatives and residents' meetings were available for people to keep updated about the service and give feedback. There was a complaints process in place.

Although assessment, auditing and monitoring of the service took place, this was insufficient and not designed in a way to address existing shortfalls and make improvements. Despite continued breaches at previous inspections, little improvement was seen in relation to these which meant people were still being put at risk.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Systems and processes to effectively identify safeguarding concerns were not suitably robust to protect people.

The service did not have appropriate arrangements in place to manage medicines safely. Individual risks to people were not appropriately assessed and managed to maximise safety.

Deployment of staff needed improvement at times. Recruitment procedures were not effective and appropriate checks were not undertaken to ensure suitability of staff.

Is the service effective?

Inadequate

The service was not effective. Staff received supervisions and felt supported but we found staff had not received some training relevant to their roles and responsibilities. Competence and skills of nursing staff was not effective to meet people's needs.

Consent was not always sought in accordance with the Mental Capacity Act 2005 and we saw it was applied inconsistently.

People spoke positively about the food but improvements were required to ensure people's nutritional needs were accommodated.

Is the service caring?

Requires improvement

Areas of the service were not caring. Although staff interactions were primarily positive, these were mainly centred around tasks.

People gave mixed comments about staff and how they were cared for.

Information about care for people at the end of their life did not guarantee people's wishes would be followed.

Is the service responsive?

Inadequate

The service was not responsive. People were not always supported in accordance with their needs and care provided was inconsistent.

Although we saw activities take place, there was limited stimulation available for people who were not able to attend these.

'Relatives and residents' meetings were available for people to keep updated about the service and give feedback.

Is the service well-led?

Inadequate

The service was not well-led. Despite continued breaches at previous inspections, little improvement was seen in relation to these.

Summary of findings

Although assessment and monitoring of the service took place, this was insufficient and not designed in a way to address existing shortfalls and make improvements.

There was no registered manager in place and frequent changes of management had left some staff unsettled. Some people were not sure who managed the service.

Dalewood View

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 8 and 10 December 2015. This was an unannounced inspection which meant no one at the service knew we would be visiting. The inspection team on the first day consisted of three adult social care inspectors and a specialist advisor who was a registered nurse. On the second day of the inspection, the team consisted of two adult social care inspectors and a pharmacist inspector. The inspection focussed primarily on nursing care and provision due to concerns we identified at our last inspection, as well as ongoing concerns, within this area.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of safeguarding concerns, deaths and serious incidents. We also gathered information from the local authority contracts and safeguarding team, the CCG (clinical commissioning group) and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived at the service. We spent time observing the daily life in the service including the care and support being delivered. We looked around different areas of the service including communal areas and people's rooms.

We spoke with fifteen people and ten relatives and friends of people, living at the service. We spoke with the director of operations, the home manager, the regional operations manager, the regional support manager, two nurses, four care workers, the cook and kitchen assistant, and a domestic worker. We also spoke with the local GP, a CCG professional and a member of the SALT (speech and language therapy) team who attended the home at different times during our inspection.

We reviewed a range of records including eight people's care records, medication administration records, four staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that the service was failing to meet the requirements of the regulation to ensure that people received safe care and treatment. The provider sent an action plan stating how they intended to achieve compliance. At this inspection we found insufficient improvement had been made .

Although we received some comments of dissatisfaction with the service, people we asked directly told us they felt safe. Positive comments from friends and relatives included: "No worries, it's nice to know he is cared for and safe" and "Never had any concerns." Despite these comments, we found that the service being provided was unsafe, particularly for people in receipt of nursing care.

We saw that people had access to call bells where they were able to use these. People told us response times were variable. Comments included, "You're sometimes waiting ten minutes. One time it's been as long as an hour", "When I press the buzzer it can be a few minutes to half an hour for staff to come", "I press my buzzer if I need the toilet, staff are ok, you sometimes wait a bit", "All rooms have a buzzer, they [staff] come quickly" and "I have a buzzer if I need it, staff come quick". During the inspection, we saw that staff responded to call bells promptly.

Staff we spoke with in the main, told us the staffing levels in place were adequate. One staff member said they felt staffing was adequate, however on a couple of occasions the day shift would have benefitted from an extra staff member. The regional operations manager told us that there were still some vacancies for nursing and care staff which were being recruited to and that the use of agency staff had reduced significantly. On the second day of our inspection, an agency nurse was working. During our inspection we saw some occasions where there was a lack of staff presence in communal lounges and not enough staff presence to offer support for people to eat on the floor for people requiring nursing care. Improvements were required as to how staff were deployed to ensure people received appropriate support.

We looked at care records and saw individual risk assessments in place so that staff could identify and manage any risks appropriately. Although a range of risk areas were covered, information was not always being followed and the level of risk were unclear in some instances. For example one person's care plans stated the person was at high risk of falls. The person had two separate falls risk assessments in place. One of these assessments rated the person as low risk of falls, whereas the other rated them as medium risk of falls. This meant the risk assessments contradicted each other and neither corresponded with the information in the person's care plans. Differing risk assessments giving different scores for the same risk can result in people not being supported safely as it is unclear what actions to mitigate the risk are required. Staff we asked were also unsure about the person's risk and the fact they did not have clear information to rely upon may have led to the person receiving inappropriate support.

We looked at the daily records of a person whose health had deteriorated a few days prior to our inspection. Although emergency assistance was sought, the decision was made not to take the person to hospital. The person deteriorated and no further medical assistance had been sought by nursing staff monitoring the person. The person's family members ultimately requested the person's GP visit them. The senior management team we spoke with acknowledged there had been a failure to seek appropriate medical treatment by staff in a timely manner. They agreed that even if was believed that a doctor had already been requested, as we were informed, then this should have at least been followed up upon the person's condition worsening.

At our last inspection we found that medicines were not handled safely. Most significant concerns related to people in receipt of nursing care. During this inspection we looked again at medicines management for people in receipt of nursing care and found that medicines were still not handled safely. We also found many previous issues identified at prior inspections still occurring.

There was a failure to obtain sufficient quantities of medicines to maintain continuous treatment. For example, two people ran out of analgesics and one person ran out of eye drops for dry eyes for several days. Records regarding the administration and stock levels of medicines were not clear and it was not easy to ascertain exactly how long people were without a supply of medication. We found instances where stock levels did not tally with records which meant it was not possible to tell exactly what medicines in what amounts had been administered. It is

Is the service safe?

vital that records about medicines are clear and well-kept so it is possible to tell easily exactly what medication has been given and if the medication has been given as prescribed.

- We saw inconsistent practices regarding the use of topical creams. Staff gave differing information from staff about what creams people needed. For example, one staff member said one person used a cream every other day whereas another said the person used it only when needed. One person we asked told us that it "depended on which staff come in" as to how often they received a specific cream they needed. We also found that creams were still being stored in people's rooms with no risk assessment to show they were safe to be stored there. One person's cream had been discontinued by their GP almost a month before our inspection and they had been prescribed a different cream in place of this. We saw both creams were available in the person's room to use. Records showed occasions when the person had had their old cream applied after it had been discontinued. This error was contributed to by a failure to take action to remove and dispose of the discontinued cream promptly.

Although there were 'protocols' to follow when people were prescribed medicines to be taken 'as required', we found that the information had still not been individually tailored for each person where relevant. For example, one person was prescribed separate medicines for angina, constipation and pain but there was no information about how the person would present with symptoms of each condition. In addition, there was no information to guide staff as to which dose to give when the medicine was prescribed as a variable dose. Management and nursing staff attributed this decision to the prescriber; however nurses who know the people receiving the medicines should have been able to make clinical judgements about this themselves.

One person was prescribed thickener to be used in their fluids to reduce the risk of choking and aspiration when drinking. A day before our inspection, the person had a choking episode and was taken to hospital. After discharge back to the home the same day, it was recorded that the person needed stage 2 thickened fluids. The records accessible by care staff that made the drinks were not updated to reflect this and still had not been updated when we left the home on the second day of the inspection. There was no information recorded on the MAR charts that the person was prescribed a thickener so there was a risk that unfamiliar staff, such as agency nurses, giving medicines may not administer them safely. The regional support manager assured us that they would update the correct information for the person.

We saw evidence that checks were undertaken of the premises and equipment. We observed that some people's rooms appeared cramped and had furniture set out, or equipment stored, in a way which left little room for people to manoeuvre which could have posed a falls risk.

One person told us about an occasion where there had been a previous fire drill by saying, "They had a fire drill and just left me alone." On the first day of the inspection, a fire alarm was activated and we made our way to the reception area. The fire panel showed where the alarm had been activated, but it was unclear who had taken overall responsibility for carrying out the fire drill. There was no evidence of a fire marshal, or the signing in book being used to account for people in the building. It was not until the regional operations manager took control that this was found to be a false alarm. However, it was noted that this person was not permanently on-site and managers agreed to review how this incident was dealt with in the coming days so that staff and people knew what they should do and what their responsibilities were.

The service was still not meeting the requirements of the regulations in relation to the provision of safe care and treatment. This failure evidenced a continued breach of the regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the staff recruitment records for four staff members. The records contained a range of information including application forms, interview notes, employment contracts and Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions. We saw evidence that the nurse's Nursing and Midwifery Council (NMC) registration had been checked.

One staff member had a reference in place where we were unable to ascertain in what capacity the person knew the staff member. Their other reference from a previous employer stated the staff member had been dismissed but there was no information relating to the nature of this or evidence as to what further enquiries had been made. From information present it could not be established the

Inadequate

Is the service safe?

staff member was of good character and had the competence, skills and experience for the role. We found also that there was a concern in relation to the staff member's professional registration which had not been fully explored or risk assessed. The regional operations manager could not locate the required information in relation to this. On discussing specific aspects of this staff member's recruitment, the regional support manager told us they had contacted the human resources department who said that proper recruitment procedures had not been followed. This demonstrated a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. The majority of staff had received training in safeguarding and were able to provide information about their responsibilities and the procedures to follow. However, we found the process was not always effective in practice. We saw one person had a number of bruises on their arms but was unable to recall or state how they had got these. Staff we asked were also unable to account for the bruises. We saw in the person's records that the bruises had been documented on a body map several days previously and the daily record for the same day stated 'found bruises on arm and scratch on right leg'. There was no further information about the bruises or any actions taken to establish the cause of these. The regional support manager confirmed no investigation had been undertaken as it should have been, and referred the incident to the local authority safeguarding team that day.

The lack of identification and appropriate investigation into other concerns found during the inspection, for example wounds and skin tears of unknown origin, demonstrated that people were not suitably protected from risk of harm and abuse. Failure to investigate put people at continued risk of possible abuse. This evidenced a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection we found the provider was failing to meet the requirements of the regulation to ensure that staff were suitably trained and supported to enable them to deliver care to people safely and to an appropriate standard. At this inspection we found that there were still shortfalls in this area.

Two members of care staff were positive about the induction and training they had received. We reviewed the service's training spreadsheet and looked at staff records. We saw that staff were provided with a range of training relevant to their roles. The training spreadsheet showed that some staff had still not received key training in certain areas, for example fire safety and safeguarding. One nurse was shown on the matrix as not having received training in dementia or the Mental Capacity Act. We also found that three nurses were not listed on the training matrix so it was not possible to accurately identify and monitor their training needs from this. The staff training matrix documented that only four members of staff had completed training in end of life care. No nurses were listed as having completed end of life care training. Without skills and knowledge in key areas, there was a risk that people may not receive appropriate support.

We spoke with a speech and language therapy team assessor who was visiting to assess a person in the home. They said information about thickeners was not always followed by staff and they did not always know basic information such as amounts of thickener for different stage thicknesses. They cited an example of a nurse describing the incorrect amount of thickener that was required to achieve a specific thickness. This meant there was a risk that staff did not have the competence of how to effectively use prescribed thickeners which placed people at risk of harm. The regional operations manager told us one nurse had not fully understood how to complete monitoring of fluid charts, due in part to language barriers. Although we saw competence checks were undertaken with nursing staff, these examples demonstrated instances where staff did not have the required skills and competence to undertake their roles effectively.

These findings demonstrated that staff still did not exhibit and possess the appropriate competence and skills for their role. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervisions are meetings designed to support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. Staff we spoke with told us they had received supervisions and appraisals and felt supported in their roles.

People and relatives expressed mixed views about the effectiveness of the care they or their family member received. One relative told us they were not always kept up to date about changes to their family member's health and had received differing information from staff. Others said that they were pleased with how their family member's needs were met by staff and kept informed of any changes to their family member's health.

Staff said they were kept updated about people's needs by speaking with nursing and senior staff and handover records. Although some staff demonstrated a good knowledge of people's current health needs, throughout our inspection we saw that information was not always known by staff or staff gave differing responses about people's needs. This suggested that the current handover process was not robust enough to be effective to ensure people received continuity of care. On the second day of our inspection the agency nurse told us they had arrived late as they had not been informed the shift time had changed. They told us they had only worked once before at the service approximately six months ago and were not familiar with the people who lived there. This meant there was a risk people may not receive continuous and consistent support.

Most people we spoke with were satisfied with the quality of the food. Their comments included, "Breakfast's not bad", "I get my food mashed so I don't choke. I miss sweets", "The food is nice enough", "The food is very good", "All the meals are good and you get a lot" and "I have a choice of food and they will leave off food I don't like". Menus on display showed there was a choice of meals available for people.

Inadequate

Is the service effective?

We spoke with the cook who told us a decision had been taken to introduce a better hot meal option as part of the evening meal and this had been decided in conjunction with people. They told us people's dietary needs were noted on admission and then kept under review by the nurses and senior care staff. They had details recorded of who was on specialised diets and where people had any allergies. They said that people who were able to communicate were always asked about their food preferences and for those that weren't, family members were asked to try to accommodate people's preferences.

We observed breakfast and lunchtime services and found the support from staff for people was inconsistent. Some people ate in the dining room and where people were able to eat independently they did so. People had given their meal preferences some time prior to service and were given what they had ordered. We saw some people were encouraged to eat and asked if they wanted extra food or drinks which were supplied. We saw two staff members sitting beside people who needed assistance to eat. The staff members sat level with each person, stayed with them, explained what was happening and supported them at their own pace. They regularly asked the people if they wanted a drink between mouthfuls.

However, we noted occasions of where people did not receive appropriate support. One person's care plan stated they were at risk of poor nutritional intake and that staff needed to cut up their food and offer support and encouragement with the choice of an alternative meal. We observed this person at dinner was served a meal of meat, potatoes, gravy and peas. For ten minutes the meal was in front of the person who did not touch it. A care worker supporting someone else at the time asked the cook if the person was eating. The cook then sat with the person and offered some encouragement such as, "come on, eat it up" but left after a few minutes to continue preparing other people's meals. We remained a further ten minutes, by which point the meal would have been cold. No further assistance was given to the person and no alternative was offered. Another person in their room told us they were not hungry. A care worker brought their meal but did not explain what this was or check it was what the person wanted, even as they continued to state they did not feel like the meal. We saw another person who required pureed food had been to hospital during the day for an appointment. On their return several hours later they told us they were hungry and we found no provision had been made for their food since they had eaten their breakfast at the service prior to their appointment.

Our findings demonstrated that people did not routinely receive care and treatment that met their needs in relation to their nutrition. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as identified at our last inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We saw that several people had DoLS applications in place or in the process of being applied for where it was considered that the person did not have capacity to consent to reside at the service.

When we looked in people's care records, we found that consent was not always sought in accordance with the MCA where people lacked capacity to give consent. Although we saw some good information such as capacity assessments for specific decisions and clear information about areas in which people had capacity to make decisions and how they should be supported, this was not consistent. For example, one person's pre-admission record stated that they did not have capacity to consent to their care and treatment. This was a blanket statement as discussions we had with the person demonstrated they could consent to certain aspects of their care and their capacity to consent to certain aspects of their care was also documented in

their care plans. We saw the person had bed rails in place and was said to require a lap belt to secure them in their wheelchair to prevent falls. There was no record that the use of the lap belt or bed rails were discussed with the person and no evidence of consent to their use. No MCA assessment was in place to evidence the person lacked capacity to consent and to determine that the belt and rails were in the person's best interests and the least restrictive option in the circumstances for which they were being used. We found other similar instances where the MCA had not been followed for other people.

Our findings showed that care and treatment was not always provided with consent of the person, and in accordance with the MCA 2005, where a person lacked capacity. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Within care records we looked at, we saw evidence of involvement from other professionals with people's care, including doctors, specialist nurses, opticians and dentists. People commented to us about seeing the GP and optician as a regular occurrence. During our inspection we spoke with the local GP, a professional from the local clinical commissioning group and an assessor from the speech and language therapy team who were present at separate times. All expressed concerns about the effectiveness of the service being provided to people at Dalewood View and felt this did not always meet people's needs.

Requires improvement

Is the service caring?

Our findings

Comments from people about the staff and the care they received were variable. Positive feedback included, "I enjoy it, there are some nice [staff]", "Staff are very lovely" "You can't fault the staff", "Staff are very helpful" , "They're very good", "I like it here, the staff are good", It's ok here" , "I'm quite comfortable", "I can have a chat and a laugh with staff" and "It's lovely here, the staff are helpful."

Most negative comments from people referred to changes in the staff team. People told us, "Keep getting new staff. Some are very nice, some just don't care", "They're ok but one or two are not bothered", "Some good staff keep leaving" and "There are a lot of staff who come and go." Two people told us, "I don't like it here."

Positive feedback from relatives and friends included ; "Staff are lovely, really nice hard working girls", "Staff are never less than helpful", "Very happy, no concerns", "Staff welcome us warmly and it's nice to know he is cared for", "Staff are smashing" and "[My family member] is still here because of the care."

One relative said some staff had a poor attitude and gave an example of staff not communicating with their relative when they had called for assistance. Other relatives also commented about staff changes as being an issue. One relative stated, "Staffing is inconsistent and there is a lot of agency staff". This person said they were happy with the care their family member received despite this. Another said, "Changeover of staff is sometimes difficult but some of the new staff are really good." Frequent changes of personnel make it difficult for people to build positive ongoing relationships with staff who support them.

We observed interactions between staff and people. Staff communicated with people in a way to suit people's needs, such as speaking slowly and clearly where people had hearing difficulties and bending down to the persons' level when speaking with them. Staff were polite and courteous with people although we saw there were sometimes limited opportunities for staff to engage with people other than when providing support. We saw one person became upset and rang their call bell. A care worker responded and spoke with person. We observed the care worker was patient, respectful and provided reassurance to the person.

Most staff explained to people what they were doing before providing assistance and involved people in decisions. For example, what would they like to do or where would they like to spend time.

We saw one member of staff had very little engagement with people. We saw in the morning they went into a person's room and started to change the bed but did not speak with the person who was sat up and awake and explain what they were doing. At breakfast, the staff member did not respond to, or acknowledge, one person who was shouting for assistance. Instead, another staff member who was engaged with other people at the same time, undertook to reassure the person and ask what they wanted. This showed that the staff member did not always demonstrate a caring and inclusive approach with people.

We saw that people had 'this is me' documents in place. These are good practice documents which provide background information about a person. This includes information about a person's life history, preferences, family, hobbies and communication amongst other things. They are designed to enhance the care and support given to people, especially when they first move into a new or unfamiliar environment such as transferring to a care home.

Staff we spoke with were able to give examples of their practice to ensure people were treated with respect. Most people we asked told us they were treated with respect. One person said, "I keep my door open, [staff] close the door when I get dressed." We observed most staff knocking on people's doors during their work. We saw people looked presentable however some people had commented that personal care did not meet their preferences which meant there was a risk their dignity and respect was compromised in this area. Another person said "I don't see staff much, they just look at my feet and give me tablets".

On both days of our inspection, the nurse's room where people's care plans were kept was often left open. Visitors would and could have access to this room if they so chose. This meant there was a risk that confidential information about people could be seen by unauthorised people. This could compromise their safety, dignity and respect. This demonstrated a failure to maintain secure records for people using the service. On the residential floor, we noted that the room where care records were kept remained secure when not in use.

Requires improvement

Is the service caring?

In the reception area of the service there was a range of information available for people and/or their representatives including details of advocacy services. Advocacy is a process of supporting and enabling people to express their views and concerns. The service had an advocacy policy in place.

We found that one person was currently receiving end of life care and had a 'death and dying' care plan in place. However it had not been updated since February 2014 which meant it had not been reviewed to ensure the information was still current. It also stated the person practiced a certain religion and staff 'should be aware of' this but not whether and what, if anything, they should do with regards to that information and how that was pertinent to the care they provided at the end of life. For example whether this meant there were certain practices that would need to be followed to in order to respect the person's faith. We asked the clinical lead about this who was unable to explain further. This meant there was a risk that people may not receive support they required in a caring, dignified and respectful way.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider was failing to ensure that people living at the service had care and treatment to meet their needs. The provider sent an action plan stating how they intended to achieve compliance. At this inspection we found insufficient improvement had been made .

Where people required support with their needs, some people felt their own choices were not accommodated. One person told us "I prefer a shower. They [staff] give me a quick wash instead." They told us they could not recall their last shower. Another commented that they liked to rise early but then had to wait several hours before breakfast was served when they would prefer something to eat after they had risen. One person wanted to take their medicine in liquid format but was given this in tablet form. For this person, the clinical lead said the person was able to eat as rationale for why their preference was not met. This demonstrated a lack of recognition and support to accommodate people's own choices. However, one person told us they were supported by staff to have a shower which met their bathing preference. People said they got up and went to bed when they chose. One person commented that, "I get the care how I want, staff know how to help". This demonstrated there were variances in people's experience of how staff responded to their needs and preferences.

Relative's comments were similarly variable about the responsiveness of staff. One relative felt their family member's personal hygiene and nutritional needs had not always been met when they visited. Another told us that their family member was meant to be observed closely by staff but this did not take place. Positive comments were received from friends and relatives whereby people had no concerns that their family member or friend's needs were met and were pleased with how they were looked after. One relative told us, "They [staff] are always quick to respond to anything [my family member] wants" and gave an example of their family member being seen by an occupational therapist, who suggested a specific activity to help with co-ordination . The relative said the next time they visited, the person had the resources for the activity in their room.

We saw that care records covered a number of areas which included; maintaining a safe environment, communication, mobilising and working and playing. Care plans we looked at had been subject to regular review. However, we found examples of where care being delivered did not correspond with people's assessed needs.

Prior to our last inspection in May 2015, the provider had introduced 'rounding charts' for each person. These documented care needs such as repositioning, fluid and food intake and personal care that each person received. As we had identified at prior inspections, there was still no robust process in place to monitor these charts to ensure people were receiving appropriate care and support. We found that daily fluid intake was not being totalled as per instructed on the chart and daily body maps were not always completed, again as instructed that they should be. This meant that it could not be established that people were receiving suitable care to meet their needs, and it could not be identified if, and in which areas, they required additional support.

One person was assessed as being at high risk of pressure sores. Their care plan stated they needed four hourly repositioning at night and two hourly repositioning whilst sat in their chair. The person's rounding charts, and others we saw, did not contain any information about the frequency of repositioning. They documented that on one day the person was sat continuously in their chair for a period of over seven hours and the next day for a period of five hours, with no assistance with repositioning. We asked the clinical lead about this person's pressure care and they were unable to state what their needs were and whether the person required assistance in this area. They said they believed the person could 'shuffle' and reposition themselves in their chair. They asked two separate staff members in our presence about what pressure care the person required and both gave differing answers, none of which corresponded to the directions in the care plan. This showed a lack of clarity and consistency in providing care to meet people's needs. It also meant there was an increased risk of the person developing pressure areas.

When speaking with staff about the care they provided for specific individuals, particularly in relation to what creams people used and how often, we received differing information. For example, one staff member said one person used a cream every other day whereas another said

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the person used it only when needed. Some staff were able to provide specific clear information about people's needs and how they were to be supported however this was not always consistent.

Information about people's needs and support they required was not always clear. One person's elimination care plan said staff should monitor for constipation and 'undertake a bowel chart if needed'. It did not give instructions as to when a chart should be implemented and what was to be done with the information. In addition, the rounding charts had a section to complete for bowel function so it was unclear what additional information a bowel chart would provide, especially if the rounding charts were being regularly monitored as they should have been for signs of any problems.

Another person's care plan said 'allow [name] to go to bed in the afternoon' to avoid them sitting for long periods. We heard the person asking staff to go to bed one afternoon and although staff were pleasant in their response, they did not accommodate the person's request and the person remained sat in the lounge. The same person was also stated as requiring the use of a pressure relieving cushion when sat down however we never saw them using one. This showed that actions in care plans for how people were to be supported were not always followed.

Our last inspection identified shortfalls with wound care assessment and the lack of adequate wound monitoring. We identified similar issues at this inspection. Although the service had now implemented short term care plans to monitor specific needs, they did not always identify where these were needed. Whilst speaking with one person they showed us a cut on their arm with a dressing on it. Staff we spoke with were not aware of this or how and when it had occurred. We found a daily entry from several days earlier noting that the person had scratched themselves which caused the injury but there was no care plan in place or any other reference to how it was to be treated and dressed. The regional support manager said they would implement a care plan on the day of our inspection. Another person was found to have a care plan in place for their wound three days after it had been noted as occurring which meant suitable action had not been taken at the time by the nurse documenting the wound. These findings showed that the service's wound care procedure had not been followed and people's health and wellbeing was at risk due to inconsistent and insufficient practice.

Our findings demonstrated that people did not routinely receive care and treatment that met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as identified at our last inspection.

An activities worker was employed by the service and there was an activities board which gave details of the daily activities. Activities took place on both days of our inspection in the activities room on the ground floor with people being supported to attend . On one day, school children from a local school attended and held a nativity play and we saw people who attended this enjoyed it.

One person was nursed in their bed and told us they did not join in activities but would like to partake in "cards, dominoes and bingo." Another said, "There are not enough activities, they could do with something different." Another person who was also nursed in bed said they had to watch TV all day as there was nothing else to do. One person knew about activities taking place but said they were not bothered about joining in, preferring instead to spend time in their room. Another told us "bingo and films" were available.

We saw a number of people spent time in their rooms and chose to eat in their rooms which they said was their preference. We saw limited stimulation available for people in their rooms as activities we saw were only available to people who could physically attend them including where staff could assist them. People's comments differed about social interaction with most saying staff did not have time to chat with them. One person in their room had a remote control for their TV with no batteries so they were unable to operate their TV. A care worker fetched replacement batteries and said the batteries were there "yesterday" but the person said they had been missing longer than that. There was no back on the remote which also increased the risk of batteries becoming displaced and the person not being able to operate the TV to what they wanted to watch.

Residents and relatives meetings were available for people who wished to attend these. Dates of these meetings were on display in reception and we saw minutes of recent ones which showed a wide range of information about the service was discussed. The regional operations manager told us that despite the availability of these, they were not always well attended.

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We saw the complaints process was on display at the service. Some people we spoke with expressed dissatisfaction about a number of areas but did not have any formal complaints ongoing. They said they would speak with staff or a family member should they need to. One relative told us they did not feel they were kept informed about concerns relating to a previous situation involving a staff member and their family member. We fed this back to the regional operations manager who said they had provided an update the previous week. This suggested there had been some miscommunication or misunderstanding. Another family member told us they were not happy with the care their family member received and were going to submit a formal complaint about this.

Inadequate

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Our findings

There was no registered manager in post at the service. On the first day of our inspection we found that a home manager had commenced employment the previous day. They told us that they were being supported by a regional support manager, who was not present when we arrived. The home manager was not yet familiar with people in the home or their needs, the staffing levels in place and the staff. The regional support manager attended soon after and told us this was their second week in post. This meant both staff responsible for the operational management of the home were new in post and therefore not yet fully familiar with the service. The home manager told us she had not been fully aware of the extent of historical issues and concerns with the home.

Other senior managers who later attended the home during the first day of the inspection were the regional operations manager, a regional manager and director of operations. The regional operations manager had had oversight and involvement in the home for some time prior to, and since, our last inspection in May 2015. Since that inspection, three home managers had been employed at the service meaning the current home manager was the fourth in less than seven months. There was also a new clinical lead in post who had commenced employment in September 2015.

People and relatives made reference to the changes at the home and lack of consistent management. Comments included, "You don't see the manager much", "I know the staff but I don't know the manager", "Don't see the manager often, we have just got a new one", "I've no idea who the manager is" and "I don't know the manager."

Staff had concerns about the effects of the management changes. One said constant changes meant less continuity which affected staff morale. They suggested a reason for changing managers as possibly a "lack of support from senior management." Other staff comments included, "It's been a rollercoaster", "A few different managers have meant lots of changes" ," We've had loads of help from top management. Whenever, we need anything, it is sorted out" ,"We aren't quite there yet but it has improved a lot" and "It has been a challenge sorting this place out but we are getting there alright."

At our last inspection in May 2015 we found the provider had not ensured there was an effective system in place to suitably assess, monitor and improve of the quality of the service provided and was not meeting the legal requirements of the regulation. The provider submitted an action plan of how they intended to achieve compliance. The action plan included a number of actions to be implemented as areas for improvement. This incorporated improvements in; wound care and monitoring, medication audits, effective use of rounding charts and medicines managements. We found continued shortfalls within these specific areas which meant the legal requirements of the relevant regulations were still not being met. We also found the action plan did not address all of the concerns highlighted at our last inspection which meant without actions to address the issues, there was no preventative measure to minimise the risk of reoccurrence. This demonstrated that the plan was not suitably robust.

We also found the action plan was not adequately followed up to monitor the success, outcome and sustainability of any actions that were in place. For example, one action stated that a white board to outline wound care regime for people at the service was in use within the treatment room. We saw the whiteboard and that this had not been updated since week commencing 19 October 2015, almost two months prior to the inspection. This meant that the action, although it had been implemented, had not been continued in a way that was meaningful and therefore did not assist in mitigating any risks associated with the care people received.

We found that sufficient action had not been completed by the registered provider to ensure all relevant staff were appropriately trained. The provider did not have appropriate processes for assessing and checking that nurses had the competence, skills and experience required to undertake their role. This meant people in receipt of nursing care were at risk of not being cared for by competent staff which was also evidenced in our findings relating to wound care, medicines and care planning. This showed that the system for auditing and monitoring staff training and competence was not robust which led to risk of impact upon people's care.

We saw evidence that medication audits had been completed however they were not designed in way to identify errors or highlight poor practice. This was also acknowledged by the regional support manager who

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agreed that they were not sufficient . Without robust auditing, it is difficult to identify concerns, make improvements and implement changes needed to ensure medicines are managed safely.

We looked at quality monitoring visits by senior management since May 2015 when the last inspection took place. The reports provided showed infrequent monitoring and were not comprehensive enough to address the progress of improvements in relation to the existing breaches. An interim visit on 6 November 2015 recorded in the section titled 'issues identified' 'Care plan for [name of person]', 'Charts' and 'Wound measurements' with no explanation as to what the issues were pertaining to these entries and what, if any actions were required to rectify any shortfalls in these areas. The lack of clear information made it difficult to establish where shortfalls had been identified, where actions were required and who was responsible for these.

As a result of our findings, the service was still not meeting the requirements of the regulations in relation to assessing and monitoring the quality of service provision which is a breach regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that regular staff meetings, held by the previous manager and the regional operations manager, had taken place. The minutes showed that a range of topics were discussed including progress since the last inspection, actions the provider was taking, staffing, resident care, record keeping and staffing amongst other areas.

There was a process in place to ensure incidents were monitored to identify any trends and prevent recurrences where possible. The regional operations manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

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 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive care and treatment that was appropriate and met their needs and reflected their preferences.

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not always provided with consent of the person, and in accordance with the MCA 2005, where a person lacked capacity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Risks to people's health and safety were not assessed to ensure care provided was safe. Medicines were not managed in a proper and safe way.

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.

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 Systems and processes did not operate effectively to prevent abuse and improper treatment of service users.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health, safety and welfare of people.

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not demonstrate, and were not provided with, appropriate skills, training and competence to enable them to carry out their duties effectively.

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated to ensure people involved with carrying out the regulated activities were of good character and had the skills and competence for the role.

The enforcement action we took:
Notice of Decision to vary the provider's registration to remove nursing care.