Express Care (Guest Services) Limited

Yew Tree Care Centre

Inspection report

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Ratings

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

Overall summary

We inspected Yew Tree Care Centre on 15 September and 27 October 2015. The inspection was unannounced inspection which meant that the staff and provider did not know that we would be visiting.

Yew Tree Care Centre provides both personal and nursing care to a maximum number of 76 people. There are four separate units in the service. There are two units in which people living with a dementia are accommodated and cared for, one of which is for people who require nursing care. There is a residential unit in which people who require personal care are accommodated and cared for and there is also a general nursing unit. Units are divided across three floors. At the time of our inspection there were 66 people who used the service.

The home does not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

This is a breach of the registered providers condition. The registered provider failed to notify the Care Quality Commission in respect of their absence or change in management arrangements so we issued a fixed penalty notice that they paid as an alternative to prosecution. A manager was appointed in July 2015 and was in the process of making an application to the Care Quality Commission for registration.

Systems were not in place for the management of medicines to make sure that people received their medicines safely.

We found that the manager understood the principles of good quality assurance and completed monthly audits of all aspects of the service. We found the audits identified areas they could improve upon and action plans were produced, which clearly detailed what needed to be done and when action had been taken.

However, the manager had only been in post a short time and we found that the previous system had not been effective. We found that the previous interim manager had failed to thoroughly investigate concerns and review practices at the home. We found that the previous systems had not identified the shortfalls in medication practices, implementation of the MCA, staff training, care records and infection control. The operations manager and manager acknowledged these shortfalls and told us they were addressing them.

We found that the systems in place for managing and overseeing staff training were ineffective Staff were not up to date with their training. We found that staff had not received training around managing challenging behaviour or break away techniques

We found that supervisions and appraisals were not up to date. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The manager and operations manager were aware of this.

There were insufficient numbers of staff deployed to meet the needs of people who used the service.

We received mixed comments from people who used the service and relatives about activities and outings. Some people found the activities enjoyable whilst others found them repetitive and less stimulating.

People were asked for their views during meetings and in surveys; however the results of the 2015 survey had not been analysed. This meant that the feedback that people had provided had not been reviewed to determine where improvements could be made.

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.

We checked whether the service was working within the principles of the MCA and found that it was.

During our visit we reviewed the care records of eight people. They were person centred, with individual information on people's wishes in relation to how their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported.

People's care plans included any necessary risk assessments based both on actual and perceived risk. They identified areas of risk depended on the individual and included issues such as skin integrity, mobility, nutrition and health needs. This meant that staff had the written guidance they needed to help people to remain safe.

We saw that people were provided with a choice of healthy food and drinks which helped to ensure that their nutritional needs were met. People were weighted on a regular basis and nutritional screening was undertaken.

Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety.

We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people.

Summary of findings

There were positive interactions between people and staff. People's independence was encouraged. We saw that staff treated people with dignity and respect. Staff were attentive, respectful and interacted well with people. Observation of the staff showed that they knew the people very well and could anticipate their needs. People told us that they were happy and felt very well cared for.

People were supported to maintain good health and had access to healthcare professionals and services. People were supported and encouraged to have regular health checks and were accompanied by staff to hospital appointments.

The registered provider had a system in place for responding to people's concerns and complaints. People were asked for their views at meetings. People said that they would talk to the registered manager or staff if they were unhappy or had any concerns.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were insufficient staff deployed to meet the needs of people who used the service.

Medicines were not always managed safely for people and records had not been completed correctly.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. This meant there were systems in place to protect people from the risk of harm and abuse.

Records showed recruitment checks were carried out to help ensure suitable staff were recruited to work with people who lived at the service.

Is the service effective?

Requires improvement

The service was not always effective.

Training for all staff was not up to date. Supervisions and appraisals were not up to date.

The manager and staff had an understanding of the Mental Capacity Act (MCA) 2005 and appropriate assessments were evident on care files we looked at during the inspection.

People were weighed on a regular basis and nutritional screening was completed.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who respected their privacy and dignity.

Staff were able to describe the likes, dislikes and preferences of people who used the service and care and support was individualised to meet people's needs.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some people enjoyed the activities and outings provided at the service Other people told us activities were limited.

Care records were person centred and contained evidence of personal likes and dislikes.

Summary of findings

People and relatives were asked to share their views in meetings. People told us that if they were unhappy they would tell the registered manager and staff.

Is the service well-led?

Requires improvement

The service was not always well led.

We found that the manager understood the principles of good quality assurance and completed monthly audits of all aspects of the service.

However, the manager had only been in post a short time and we found that the previous system had not been effective.

People completed surveys to provide feedback on the care and service received, however the results of the survey were not analysed.

The service had a manager who understood the responsibilities of their role. Staff we spoke with told us the registered manager was approachable and they felt supported in their role.

Yew Tree Care Centre

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.

We inspected the service on 15 September and 27 October 2015. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. On the first day of the inspection an adult social care inspector visited. On the second day of the inspection the team consisted of three adult social care inspectors, a pharmacist inspector and an expert by experience who had experience of residential care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all of the information we held about the service and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted commissioners who are involved in caring for people who used the service.

The registered provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were 66 people who used the service. We spent time and spoke with 27 people who used the service and 12 visitors. We spent time in the communal areas and observed how staff interacted with people. We looked at all communal areas of the home and some bedrooms.

Over two inspection days we spoke with the manager, the operations manager, a registered nurse, the cook, the activity co-ordinator and sixteen care staff.

During the inspection we reviewed a range of records. This included eight people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the registered provider.

Requires improvement

Is the service safe?

Our findings

At this visit we asked if medicines were handled safely. We looked at the medicine administration records for 14 people and talked to staff.

Records relating to medication were not completed correctly placing people at risk of medication errors. For example medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care staff can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

Arrangements had been made to record the application of creams by care workers. However, these records were sometimes missed. This meant that it was not always possible to tell whether creams were being used correctly.

For one person a pain relief medicine was not available for two days and could not be used as prescribed. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way. For example, one person was prescribed two medicines that could be used for aggression and anxiety. There was no care plan or guidance in place to assist senior care staff in their decision making about which would be the most appropriate to use. For another person the prescribed dose had changed but the guidance had not been updated to reflect this.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We saw that eye drops for two people with a short shelf life once opened were still being used past the recommended date of expiry. This means that the home could not confirm that these medicines were safe to administer.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had started a countdown sheet for boxed medicines where issues were found, the manager was not notified so that action could be taken. Previous monthly audits had identified similar issues to those that we found in the home and an action plan was in place.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements that were in place to ensure safe staffing levels. During our visit we saw the staff rota, spoke with people who used the service, staff and relatives and also carried out observation. The residential unit can accommodate a maximum number of 24 people. At the time of the inspection there were 22 people. Staffing on this unit from 8am until 8pm was five care staff, one of which was a senior care assistant. Overnight there were two care assistants. The dementia nursing unit can accommodate a maximum number of 10 people. At the time of the inspection there were eight people who used the service. Staffing on this unit from 8am until 8pm was one nurse and two care assistants. Overnight there was one nurse and a care assistant. The dementia residential unit can accommodate a maximum number of 25 people. At the time of the inspection there were 20 people. Staffing on this unit from 8am until 8pm was five care staff, one of which was a senior care assistant. Overnight there were three care assistants. The general nursing unit can accommodate a maximum number of 16 people. At the time of the inspection there were 16 people who used the service. Staffing on this unit from 8am until 8pm was one nurse and three care assistants. Overnight there was one nurse and a care assistant. We received mixed comments from people who used the service and relatives about their thoughts about whether there were enough staff on duty to meet people's needs. Comments received included:

"The girls have too much to do they're always busy."

"The carers don't have time to chat." They have time to chat."

Requires improvement

Is the service safe?

"Nothing could be better for her here."

On the general nursing unit people, relatives and staff did not think there was enough staff to meet people's needs. For part of the inspection we sat and observed people and staff on the general nursing unit. Staff were busy and people were left unattended for up to 15 minutes at a time. One person who used the service said, "It's very rare that I get washed before 11am. I don't mind tennish but 11am is too late." Another person said, "I feel that staff haven't enough time for me. I sit here and keep myself to myself and they let me." One person who needed two people to help them with their personal care told me that they had to wait up to 30 minutes to use the toilet. They said, "The staff are good but there's not enough of them." One visitor told us that insufficient staffing levels had compromised the dignity of their relative. We pointed this out to the manager and operations manager who said that they would look at staffing levels as a matter of importance.

We found that dependency levels on the general nursing and dementia nursing units was high with all bar one person needing at least two staff to attend to their care needs and one person because of their level of aggression needed at least three staff to assist them to attend to their personal care needs. We found that staff did not work across the units. We were told that consideration had been given to more effective use of staff across the home so looking at staggering meal times but at the time of the inspection this had not been implemented.

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

We looked at personal emergency evacuation plans (PEEPS) for people who used the service. PEEPS provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. We found that for those people who were admitted after 5 August 2015, PEEPS had not been developed. We pointed this out to the manager who said that they would develop these as a matter of importance. The manager e-mailed us after the inspection to confirm that PEEPS had been updated.

We saw records to confirm that evacuation practices had been undertaken in September 2015; however there had not been any fire evacuation practices prior to this date.

The registered manager said that they were to do other fire evacuation practices to ensure that all staff had taken part. The manager e-mailed us after the inspection to inform that further fire evacuation practices had taken place.

An up to date fire risk assessment was not available on the day of the inspection. However, after the inspection the administrator sent us a copy of the fire risk assessment that had been completed on 14 August 2015.

Care staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. One care assistant referred us to a notice displayed in the staff base which detailed the referral process and contact details. They also told us they were aware of the whistleblowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously. Our discussions with care staff demonstrated they had a good working knowledge of their responsibilities to protect vulnerable people from abuse.

We looked at the arrangements that were in place to manage risk so that people were protected and their freedom supported and respected. We looked at the care records relating to eight people who used the service. People's care plans included any necessary risk assessments based both on actual and perceived risk. The identified areas of risk depended on the individual and included issues such as skin integrity, mobility, nutrition and health needs. Staff at the service used recognised assessment tools for looking at areas such as nutrition and tissue integrity. We saw where risks had been found, risk reduction strategies had been identified. For example one person had been identified as at risk of falls. Care records showed the person falling earlier in the year. The risks had been identified and the person was referred to the community fall's team. We saw the advice given following the assessment had been translated into the care plan. The care plan required the person to have correctly fitting foot-wear and for their room to be free of clutter and trip hazards. Our observations of the person and their room showed the advice was being adhered to.

We saw the outcome of a risk assessment where the person lacked capacity to make their own decisions about the use of bed-rails. The person had an appointed advocate who had participated in the best interest meeting. Care records

Requires improvement

Is the service safe?

showed the outcome of a discussion with the advocate which had resulted in the use of bed-rails. We saw evidence of monthly reviews of risk assessments. Discussions with two members of staff showed they were knowledgeable about the care needs of people including any risks and when people required extra support.

The manager told us that the water temperature of baths, showers and hand wash basins were taken and recorded on a regular basis to make sure that they were within safe limits. We saw records that showed water temperatures were taken regularly and were within safe limits. We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, fire extinguishers, emergency lighting and hard wiring.

We saw certificates to confirm that portable appliance testing (PAT) was up to date. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. This showed that the provider had developed appropriate maintenance systems to protect people who used the service against the risks of unsafe or unsuitable premises and equipment.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw that a monthly analysis was undertaken on all accidents and incidents and that these were analysed to identify any patterns or trends and measures put in place to avoid re-occurrence.

We found that the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Requires improvement

Is the service effective?

Our findings

We found that the systems in place for managing and overseeing staff training were ineffective There were 96 staff working at the home but overall only 52% were up to date with the mandatory and condition specific training required to be completed by the registered provider. We found that no staff had completed first aid at work training and only 56 staff had undertaken first aid awareness training. Only 67 staff had completed fire training. Nine staff had completed safe handling of medication foundation training, 50 staff had completed medication awareness training but none had completed competency checks. Only 21 staff had completed a moving and handling practical. We saw some people who used the service exhibited behaviour that challenged, Staff had not received any training around how to manage behaviours that challenge, de-escallation or break away techniques. No staff had completed training in customer care. The operations manager and manager recognised the shortfalls and were taking action to address these gaps but realised it would take time to ensure all of the staff completed the necessary training.

We found that supervisions and appraisals were not up to date. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The manager and operations manager were aware of this.

This was a breach of Regulation 17 (1) (Good Governance) and 18 (2) (a) (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection, 25 people who used the service were subject to a Deprivation of Liberty Safeguarding (DoLS) order. The registered manager had submitted applications to the supervisory body (local authority) for authority to deprive them of their liberty. We checked six of the 25 applications which had been authorised and no conditions were attached.

We found the care records we reviewed contained appropriate assessments of the person's capacity to make decisions. The assessments were specific to a particular decision, for example when consideration was being given to administer medicines covertly (when medicines are hidden or disguised in food or drink). Assessments of capacity were made with the involvement of family or an appointed advocate. Examination of this persons care records showed correct procedures had been applied to ensure the medicines were administered within current guidelines. We saw best interest meetings had occurred involving the GP, family members, care staff with personal knowledge of the individual and a pharmacist. Documents demonstrated a clear treatment aim of covert medication along with the required benefits to the person's health. A qualified person had made a written statement regarding the person's lack of capacity. A review process was in place and was being enacted.

We spoke with the manager to check their understanding of current legislation regarding the Mental Capacity Act 2005. Their answers demonstrated a good understanding of the law and how it had to be applied in practice.

Where people were subject to DoLS relevant person's representatives (RPR's) were seen to have been involved in decision making and involved in the regular reviews of care needs.

We saw from care records some people had appointed attorneys by way of a lasting power of attorney (LPA). Care plans recorded where attorneys had been involved in decision making or where reviews of care plans had been undertaken.

We looked at a training chart which indicated that no of staff had attended training in the Mental Capacity Act (MCA) 2005 but 57 staff had attended training in DoLS. The registered manager was aware of the need to ensure that all staff receive this training.

Requires improvement

Is the service effective?

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. We saw completed charts to record people's fluid intake. Care records showed the service was referring people to a dietician or speech and language therapist (SALT) if they required support with swallowing or dietary difficulties. However whilst we saw care staff took appropriate action to refer people for a professional opinion we found one instance where advice given was not being translated into safe care. The person was found to be at risk of malnutrition and was of low weight with a low BMI. The dietician had advised the person should be offered a fortified diet. We spoke with the cook and examined the cook's records of people's dietary needs. The records showed no evidence of a fortified diet and the cook confirmed they had no knowledge of the need. The cook said," Care staff do not always let me know of people's dietary needs." We did however see people with diabetes and coeliac disease were recorded in the cook's records.

The cook told us that all porridge and potatoes were fortified with butter and cream. Fortified food is when meals and snacks are made more nourishing and have more calories by adding ingredients such as butter, double cream, cheese and sugar. One person who used the service told us they had gained too much weight since they moved into the service. We discussed this with the manager who said they would speak with the cook and make sure only those people who need fortified food would receive it.

We observed the lunch time of people in the general nursing unit. We saw that the food was well presented and the portions generous. Two choices of food were given to people who used the service. People were provided different flavours of juice. Those people who needed assistance from staff received this. Some people chose to eat their meal in the dining room; some in the adjacent lounge and some people chose to eat their meal in their bedroom. Most people told us that they enjoyed the food that was provided they said, "The food is really good. I can't complain." Another person said, "We are always well fed." Two people who used the service told us that on occasions the meat was tough. They said, "Some days it's good [meat] others it's awful." We pointed this out to the manager and operations manager who acknowledged this and said they were addressing this with the supplier.

We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. The manager said that they had good links with the doctors and community nursing service. The manager said that those people who wanted had received their annual flu vaccination. One person who used the service who had broken their hip told us how staff had been helping them with their physiotherapy exercises. People and relatives confirmed that medical advice was sought were needed. People were supported and encouraged to have regular health checks and were accompanied by staff or to hospital appointments.

Good

Is the service caring?

Our findings

People we spoke with during the inspection told us that they were very happy and that the staff were caring. People said:

“The girls are always nice.”

“The staff are brilliant.”

“The staff are ok I get on well with them. Some are quite funny. They keep me in touch with things. One member of staff is particularly good.”

“It’s absolutely fantastic. No matter what it is they will break their neck to get it right for you. I’m looked after well.”

However one person who used the service said, “Some staff are good and some are not. They ignore the ones who can’t help themselves.”

Relatives we spoke with said:

“The staff are marvellous – can’t fault them.”

It’s a lovely place, The staff are lovely. He is well looked after.”

“The care is good. The staff are caring.”

People were comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs. We spoke with one person who had chosen to remain in their room. We asked if staff came to see them during the day, they said, “Oh yes they (staff) pop in all day long.” We said they looked very comfortable, in response they said, “Of course I am, I am well looked after here.” However we did see a small minority of people who would benefit from having their nails cleaned.

We saw that staff treated people with dignity and respect. Staff were attentive, respectful, were patient and interacted well with people. Staff were friendly and smiled at people. We saw that people’s privacy, dignity and human rights were respected. For example, staff asked people’s permission and provided clear explanations before and when assisting people with personal care. This showed that people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment.

An assessment at the point of admission was complimented by a detailed life history completed by the person or their relatives. The history was written in the first person and gave staff a clear understanding of people’s past. All the staff on duty that we spoke with were able to describe the individual needs of people who used the service and how people wanted and needed to be supported. For example, they could tell us the individual routines of people who used the service. Staff we spoke with told us they enjoyed supporting people. One staff member said, “I love working here.”

We saw that bedrooms had been personalised and contained pictures and ornaments. We saw that some people had brought in items of furniture such as their favourite chair or table. We saw that people had free movement around the service and could choose where to sit and spend their recreational time. The service was spacious and allowed people to spend time on their own if they wanted to. We saw that people were able to go to their rooms at any time during the day to spend time on their own. This helped to ensure that people received care and support in the way that they wanted to.

Staff we spoke with said that where possible they encouraged people to be independent and make choices such as what they wanted to wear, eat, drink and how people wanted to spend their day. We saw that people made such choices during the inspection day. Staff told us how they encouraged independence on a daily basis. We saw this during the inspection when staff supported people to walk independently. Staff provided encouragement and praise. This showed that staff encouraged independence.

At the time of the inspection some people who used the service required an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. We saw care records indicated where advocates had been involved in constructing care plans. We saw records existed to show advocates had been involved in reviewing care plans.

Requires improvement

Is the service responsive?

Our findings

The manager told us that two activity co-ordinators were employed to arrange activities and outings for people who used the service. One activity co-ordinator worked 30 and the other 24 hours a week. People who used the service and relatives provided a mixed response when we asked if there were a plentiful supply of activities. One person said, “The activities are quite good.” A relative told us there had been a singer who had come into the home to entertain people and that had been enjoyable. Another relative told us how people had enjoyed a recent trip to the sea front for fish and chips and ice-cream. One person told us they enjoyed gardening and there was a greenhouse and also a raised bed wherethey could grow produce. They proudly showed us the onions he had harvested.

Some people who used the service told us that activities were not stimulating and they were bored. One person said, “You get fed up sitting here. There’s nothing going on. I get fed up not being able to do anything. My bottom gets sore sitting all day. I’ve never seen anything going on.” One person told us they used to go shopping with staff but now they do the shopping for them. They would like to go out more. A relative we spoke with said they had never seen any activities taking place on the residential dementia unit. They told us they had bought as small chest for activity equipment and when they visited they interacted with other people who used the service. This relative cited boredom as the main issue but commented that the overall care was good. One person said that bingo took place every Wednesday but they did not join in as they didn’t like the game.

We spoke with an activities coordinator to gain an understanding of the range of activities and their role in achieving a stimulating environment. They told us activities were planned on a daily basis around a recurrent weekly theme. People had the opportunity to participate in activities both in the home and in the community. We saw a timetable of activities displayed which did not match what was happening during our visit. The schedule stated that a shopping and library visit would take place but instead there was a coffee afternoon. We were told that the timetable was just a rough guide.

On the afternoon a coffee afternoon took place on the nursing dementia unit and some people who used the service engaged in singing. We observed that a number of people did not engage in any activity. We saw little interaction between people with most preferring to sit alone or in a communal lounge. We spoke with the manager and operations manager about the mixed responses we had received about activities and our observations. We talked about missed opportunities for activities for example care staff were observed to set to lay tables for lunch yet people who used the service were not involved with this. The manager said that they would speak with the activities co-ordinator and review activities.

During our visit we reviewed the care records of eight people. They were person centred, with individual information on people's wishes in relation to how their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported. The care plans also showed what people or their relatives had told staff about what provoked their anxieties and behaviour that challenged. We saw some people who exhibited behaviour that challenged and care records clearly recorded triggers and action for staff to follow to ensure the wellbeing of the person. Care plans recorded all episodes of behaviour that challenged, the actions of staff and learning point to minimise recurrence. Care plans recorded what each person could do independently and identified areas where the person required support. Where support was needed the number of staff needed for each element of care was recorded. For example, people who needed a hoist to be safely transferred from a wheelchair to bed were noted to require two staff. We found that care plans had been reviewed and updated on a regular basis.

During the inspection we spoke with staff who were extremely knowledgeable about the care that people received. People who used the service told us how staff supported people to plan all aspects of their life.

The manager told us the service had a complaints procedure, which was provided to people and their relatives. Staff were aware of the complaints procedures and how they would address any issues people raised in line with them. We looked at the complaints register to find 15 complaints had been received since the beginning of 2015. We saw the complaints reflected some degree of repetition in that food and the availability of cutlery and crockery accounted for 5 of the complaints (33%). On the day of the inspection people and relatives also mentioned about the lack of crockery and cutlery available on each individual unit. Most of this was kept in the main kitchen

Requires improvement

Is the service responsive?

area but at times during the day when people and relatives wanted a cup of tea this was not always available. People and relatives also pointed out that washing up liquid was not always available within the units and that cups and mugs were often stained. We saw the current manager who had been in post for four months had reviewed the system of responding to complaints. We saw all complaints had been responded to within 28 days of the complaint being received. People and relatives spoken with during the inspection said that they would feel comfortable in speaking with staff or the manager to make a compliant.

Requires improvement

Is the service well-led?

Our findings

The manager started work at the service in July 2015. They confirmed they were submitting their application to the Care Quality Commission to apply to be the registered manager. The last manager of the service left in May 2015. The registered provider failed to notify the Care quality Commission in respect of their absence or change in management arrangements so we issued a fixed penalty notice that they paid as an alternative to prosecution.

We found that the manager understood the principles of good quality assurance and completed monthly audits of all aspects of the service, such as infection control, medication and learning and development for staff. They took these audits seriously and used them to critically review the service. We found the audits routinely identified areas they could improve upon. We found that the manager produced action plans, which clearly detailed what needed to be done and when action had been taken.

However, the manager had only been in post a short time and we found that the previous system had not been effective. We found that the previous interim manager had failed to thoroughly investigate concerns and review practices at the home. We found that the previous systems had not identified the shortfalls in medication practices, implementation of the MCA, staff training, care records and infection control. The operations manager and manager acknowledged these shortfalls and told us they were addressing them.

We saw that a survey had been carried out for those people who used the service in January 2015. However the results of the survey had not been analysed and an action plan had not been developed. This meant that the feedback that people had provided had not been reviewed to determine where improvements could be made.

Staff, relatives, management and meetings for people who used the service were undertaken; however the manager was only able to provide us with minutes of meetings since they were appointed. Whilst the minutes reflected a wide range of relevant issues were discussed there was evidence these were not being used to improve quality. For example, we had seen evidence from complaints about the unavailability of crockery and cutlery going back to February of 2015. The minutes of the relatives and meeting of people who used the service on 27th August recorded the same issue. Discussion with the manager showed the problem was still present at the time of our inspection. Whilst we were told supplies of crockery and cutlery had been ordered we noted that this assurance had been given to complainants in the past, there was little evidence it had ever been resolved.

Our discussions also showed the shortages of crockery was leading to staff washing crockery in the kitchen preparation area in each lounge without a supply of washing-up soap. This meant we could not be assured crockery was being adequately cleaned or cleaned at a high enough temperature to protect people from harm of infections.

This was a breach of Regulation 17 (1) (Good Governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with said they felt the manager was supportive and approachable, and that they were confident about challenging and reporting poor practice, which they felt would be taken seriously.

All the staff we spoke with were clear about their role, responsibilities, expectations on them and culture and values of the home. They felt appreciated and supported by the registered provider, the manager and their colleagues. One staff member said, “I think the care is really good. There is good team work and I enjoy coming to work.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with unsafe systems for the management of medicines. Regulation 12(2) (f) (Safe Care and treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient staff deployed to meet the needs of people who used the service. Regulation 18(1) (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not suitably trained to enable them to carry out the duties within their role. Supervisions and appraisals were not up to date. Regulation 18(2) (a) (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

People who used the service and others were not protected against the risks associated with ineffective monitoring of the service. Effective governance arrangements were not in place.

Regulation 17(1) (Good governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.