Care Quality Commission

Clarendon Care Group Limited

Myford House Nursing & Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 1 and 2 February 2016 and was unannounced. We briefly returned to the home on 5 February 2016 to collect some documentation that we had requested. At the last inspection completed on 6 May 2014 the provider was meeting all of the regulations required by law.

Myford House Nursing and Residential Home is a service that provides accommodation, personal care and nursing care for up to 57 older people. At the time of the inspection there were 47 people living at the home with a range of needs including people living with dementia. There was no registered manager in post. The registered manager had left the home in September 2015. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A Chief Operations Officer commenced working at the home in September 2015 to provide management and leadership and was supported by a support manager. A new manager had been appointed and commenced working at the home on 11 January 2016 and was due to submit an application to be registered.

Although most people told us they felt safe and staff knew how to protect them from potential harm the practices we saw and records we reviewed did not support this. Safeguarding incidents were not always recognised, dealt with or reported appropriately. Risks to people had not always been identified or effectively managed. Staffing levels were insufficient to meet people's individual needs or to maintain their safety. Care was delayed because of the deployment and management of the staff. Systems to manage medicines were not always safe or effective and appropriate standards of hygiene were not always maintained.

New staff did not receive an effective and comprehensive induction to their work and not all staff had received essential training or updates. Staff told us they worked to the best of their abilities. People's day-to-day health needs were not consistently met. People had access to external healthcare services when needed but recommendations made by some professionals had not been fully actioned. People's records had not been immediately reviewed or updated to reflect their current needs. People were offered a choice of meals and enjoyed the food and drinks they received. However, records were not appropriately maintained so we could not be confident that people's dietary requirements were being met. Staff knew how to gain people's consent when supporting them but lacked an understanding and knowledge of protecting people's rights. Staff were not aware of who was deprived of their liberty or what restrictions were in place.

Staff were caring in their approach and worked hard to attend to people's needs. Care staff did not have time to sit and talk with people for any meaningful periods of time as they were busy focused on completing the tasks required of them. Most relatives we spoke with were happy with certain aspects of the care provided but raised concerns about low staffing levels, supervision of people and a lack of communication. People had access to an activities programme during the week, which they told us they enjoyed but had little to do at weekends. People were supported to maintain relationships that were important to them. People's dignity, privacy and independence was mostly respected.

Most people did not feel involved in planning and reviewing their care. Care records were not up-to-date or person-centred and lacked detail about the support people required. Thisplaced people at risk of receiving unsafe or inappropriate and unsafe care. People knew how to make a complaint but not everyone was confident that concerns raised were acted on.

People had experienced a number of changes in the management team, which had led to a lack of consistent leadership. The lack of strong and consistent leadership underpinned many of the failings we identified. Poor communication systems, the lack of co-ordinated team work and inconsistent staffing meant managers and those in charge were not always aware of what was happening in the home. Staff told us they felt supported by the management team and found them open and approachable. People were familiar with the newly appointed manager and felt confident they could improve the quality of the service provided. Systems to monitor the quality of the service were in place but were not effective in identifying or addressing risks to people's health, safety and wellbeing or securing service improvements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

Summary of findings

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.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff to meet people's needs and keep them safe. People did not always receive their medicines as prescribed. Risks to people's health, safety and welfare were not properly assessed and reviewed. Safeguarding incidents were not always recognised or reported. Appropriate standards of hygiene were not always maintained.

Inadequate

Is the service effective?
The service was not effective.

People were supported by staff who had not received effective training to carry out their work. People's consent was sought before staff provided care but staff lacked knowledge of how to protect people's rights. People enjoyed the food and drink they received but records were not maintained effectively to monitor people's dietary requirements. People were supported to access health services when needed but advice provided was not always acted upon.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were supported by staff that were kind and caring but did not have opportunity to spend meaningful time with them. People's privacy and dignity was mostly respected. People were supported to maintain relationships that were important to them but were not always involved in planning and reviewing their care.

Requires improvement

Is the service responsive?
The service was not responsive

People's care needs had not always been reassessed and not everyone felt involved in planning their care. People had access to a range of activities during the week. People knew how to make a complaint but not everyone was confident their concerns were acted on.

Requires improvement

Is the service well-led?
The service was not well-led

There was no registered manager. A lack of consistent leadership and ineffective quality assurance systems meant people did not receive a high quality service.

Inadequate

Myford House Nursing & Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 February 2016 and was unannounced. We briefly returned to the home on 5 February 2016 to collect some documentation that we had requested. The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. The specialist advisor was a qualified nurse who has experience working with older people and people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the Local Authority, the Clinical Commissioning Group and Healthwatch. We also reviewed information that had been shared with us by the members of the public. We used this information to help us plan our inspection.

During the inspection we spoke with 14 people living at the home. We spoke with the Chief Operations Officer, the manager, the deputy manager, the clinical lead and 19 members of staff, including nursing staff, an agency cook, an administrator and the activities coordinator. We also spoke with six visitors who were relatives or friends of people living at the home. We looked in detail at eight people's care and reviewed elements of records relating to other people's care. We reviewed three staff files and records relating to the management of the service. We observed care practices and how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People shared concerns with us about the staffing levels and the high use of agency staff. One person told us, "You have to wait in the morning. You have to wait your turn". Another person said, "They could do with more people as it leads to a delay in some people's care". They went on to say, "When my family come they have difficulty finding them (staff)". One person said, "They've got such a lot to do. They're run off their feet all the while". Professionals also shared concerns with us when they had recently visited the home on two occasions. They found two people were seeking staff support in specific areas of the home and no staff were present to provide assistance.

Staffing levels were insufficient and had not been regularly reviewed to respond to people's changing needs or incidents that had occurred. We saw people had to wait for their care as care staff were consistently busy attending to people's needs in communal areas and in people's own rooms. Therefore staff were unable to spend meaningful time with people. The layout of the home meant it was difficult for staff to monitor people to ensure their safety. Staff were allocated to work in small teams across four areas of the home providing care to people in each area. Managers told us they were looking to revise staff team allocations across the home and used a staffing tool to provide a general guide to the number of staff needed. They said staffing had not been reduced despite a reduction in the numbers of people currently living at the home. During the inspection we saw staff were not directed or deployed to keep people safe or to attend to people's immediate needs. We observed that the main lounge on the ground floor was at times left unsupervised for periods when staff were either attending to people's needs or trying to locate pieces of equipment from around the home to assist people. This potentially placed people at risk of harm. For example, we saw one person attempted to get up from their chair on two occasions while waiting for staff assistance. We saw a person's dignity was compromised in another area of the home because staff were supporting people elsewhere. Another person, who was on their own in one lounge, woke up from being asleep and became anxious and requested assistance but was unable to call for help as they did not know how to use the call bell. We had to intervene and provide reassurance to the person. Two staff we spoke with told us people's personal care needs were attended to but there was often a delay due to staffing levels. Staff told us that they did not have enough time to spend with people. A relative told us they often found their family member still in bed when they visited because staff were busy attending to the needs of other people until late in the morning. Concerns were raised about severe staff shortages on Christmas day due to unplanned staff sickness. These concerns were acknowledged by the management team who advised on the action taken to prioritise people's needs and mitigate risks. They were confident that people's care needs were met.

One person told us they were unable to call staff on one occasion when they needed assistance as the call bell was out of their reach. This was confirmed in discussions we held with their relative who told us they had to verbally request staff assistance on two occasions to attend to their family member's catheter bag as it was full. During the inspection we saw most people in their rooms had access to call bells to request staff assistance, however there were occasions when these were not accessible. One person had been assessed as not being able to use their call bell and was to be checked at regular intervals. The person told us that most times staff made checks on them but other times they were left waiting for staff to check on them. We saw a person had raised concerns that when they had asked for their incontinence pad to be changed during the night they were told "staff were busy". We saw action had been taken by the management team in relation to this.

We saw a number of records where accidents and incidents had occurred and these were unwitnessed by staff; this included a significant injury to one person in a communal area of the home. Another person's records showed a number of incidents had occurred particularly during the night and staffing had not been adjusted accordingly to ensure they and other people received the level of supervision or care they required. A member of staff shared concerns about night time staffing levels. They told us, "It's really dangerous at night because some of the residents don't settle. Most need two staff to help them". They said, "Staffing is manageable on day shifts if everyone turns up". They went on to say that managers were, "not always supportive when the home is short staffed, but they are approachable and do listen". The management team acknowledged that they had experienced difficulties with staffing due to sickness and as a result had taken a "very robust approach to performance management" resulting in some staff leaving. Although new staff had recently been

employed, agency staff were being used on a daily basis. The management team told us regular agency staff were used where possible to help provide continuity of care where possible.

These issues were a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the concerns we raised about staffing levels, the provider increased day staffing levels by one extra carer. We were advised that managers were supernumerary so were available to support staff and we observed this at lunchtimes where managers helped assist people with eating. A member of the management team told us they worked alternate days at weekends to provide staff with management support.

We found risks to people were not managed safely or appropriately. Although staff were able to provide examples of how they took action to reduce risks to people, we saw risks had not always been identified and assessed. We saw care plans were in place for people receiving respite care but had not been reviewed or updated. For example, we saw a moving and handling risk assessment had not been completed for a person whose needs had changed and they required transferring from their bed to their chair using a hoist. They told us they had experienced pain when staff had last moved them due to trapping their catheter. We saw staff used a stand-aid to help move another person yet their records showed they should have used a hoist. The person told us, "I refused to go in the hoist as it was very uncomfortable. Some of them (staff) didn't seem to know where to put the straps between my legs". We saw two people being transferred in wheelchairs on two different occasions. The wheelchairs did not have footplates in place posing a risk of them injuring their feet. The new manager told us they had also observed this and had raised this with the member of staff concerned. However, our observations showed this had not been communicated across the staff team. Managers acknowledged that people's risk assessments had not been immediately reviewed when people's needs had changed.

People who were assessed as requiring equipment did not always have it. On the first day of the inspection, we saw one person was lying on a deflated air mattress. We immediately brought this to the attention of the new manager, who spoke with a carer and was told the person would be assisted to rise shortly. When we returned to the home on the second day we saw the person was again lying on a deflated air mattress. Records showed this had been reported to the maintenance team on 27 January 2016. Although records stated the pump had been removed and sent for repair, no alternative mattress had been sought for the person to sleep on. Air mattresses help in healing and preventing bed sores. When we returned to the home briefly on 5 February 2016 we saw this had been addressed. We were told the air mattress was not found faulty but had not been set at the correct setting. We saw one person's moving and handling risk assessment identified that the person mobilised with a walking stick. We observed the person did not have their walking stick with them on the two days we were at the home and staff had therefore not followed the person's moving and handling risk assessment or ensured their safety was promoted. Whilst we did see some positive examples of people being supported to move safely this was not consistent and not all staff demonstrated knowledge of people's moving and handling needs. For example, we heard a member of staff in the main lounge ask another member of staff, "Does [name of person] need hoisting from their chair?". They were unsure about what piece of equipment was used to move the person safely. We found the person's moving and handing assessment had not been reviewed and updated to reflect the equipment that was currently used. Staff did not recognise the need to take action to keep people safe or protect them from possible harm. For example, we saw an incident report where a person had climbed over their bedrails during the night and was found in another person's room. Their records stated, "Assessed as not requiring bed rails at night due to confusion. Crash mat in situ". We did not observe a crash mat in the person's room. We found a person's mobility care plan had not been updated since their return from hospital following a fracture. We saw that many people had rails on their beds to prevent falls. We observed three people were lay in their beds with either no bed rail protectors in place or these had fallen off exposing the bed rails. Records showed another person had trapped their leg in their bed on two occasions. On the first occasion records completed by staff showed there were no bedrail protectors in place. On the second occasion there was no record of the person being checked throughout the night for nearly seven hours when staff found them in pain and their leg trapped. The Chief Operations Officer advised us that people were checked two hourly throughout the night. Records seen and discussions held with a member of staff

showed the same person's call bed had been tampered with on one occasion therefore they were unable to call for assistance during the night if they needed to. There was no evidence that this incident had been investigated to establish how this had occurred. We saw a system was in place to record accidents and incidents and care staff knew their responsibility to record and report these. We found some incidents had not always been reported to or investigated by managers and some incidents had not been reported to the local authority safeguarding team or notified to the Commission. Therefore action had not always been taken to review risk or improve the safety of people using the service.

We saw all care and treatment records for tissue viability for people with ulcers and wounds were kept in a separate folder. Tissue viability assessments had been completed and evaluated regularly. However, the management of information for wound care was confusing and sometimes contradictory. Staff gave examples of things they looked for when checking people's skin. These included red areas and skin breaking down. They told us they would raise any concerns with the nurse. Care plans for wound management were in place for a person whose care we looked at in detail. We saw most wounds were attended to as per the care plan but some gaps were noted. For example a person's records noted alternative days for treatment but this was not consistent with the records completed.

We saw people had a personal emergency evacuation plan (PEEP) in place that would be implemented in the event of an emergency. PEEPs are used to establish safe procedures for people who may not be able to get themselves out of the home without staff assistance. However these had not been completed for some people and others were not dated or reviewed as their needs changed. This meant in the event of a fire staff did not have up to date information about people to ensure their safety. We found a number of bedroom doors were propped open, which may have posed a risk to people in the event of a fire. Although most equipment had been checked we found no recent records of checks on bedrails and wheelchairs.

People did not always receive their medicines as prescribed. Although medicines were stored safely and securely, we found systems and processes in place to manage medicines were not always safe or effective. We saw medicines were currently administered by trained agency nurses. Records were not effectively maintained to show when medicines had been administered. For example, we found gaps on the medicine administration record (MAR) charts where staff had not signed to show that the medicine had been given. We saw this was a combination of recording issues and missed medicines. The processes for ordering medicines were ineffective as there were occasions when the service ran out of people's prescribed medicines. We found two people had not been given medicine prescribed for pain relief as there was no stock available. Managers acknowledged the need to plan ahead particularly when people were admitted to the home mid-way through the medicine cycle. We saw controlled drugs (CD's) had not always been recorded in accordance with good practice. All administrations of CD's should be witnessed by a second staff member to ensure the safe and correct doses were given to people. However, we found that this practice was not being consistently completed in line with best practice. Following the inspection it was brought to our attention that one person was prescribed medicines to alleviate anxiety, agitation and panic attacks and these had not been administered as required.

We were not able to establish if topical medicines, creams and lotions were being administered as prescribed due to the lack of protocols and information about how, where and when these medicines should be applied. MAR charts to record topical creams were not used. We checked the fridge temperature on the second day of the inspection and found the temperature was not within the recommended range for the safe storage of medicines. This meant that the medicines could be affected and may not be effective for people. Records for the previous month were not available for inspection as these had been archived. Not all MAR charts contained a photograph of the person for purposes of identity. One agency member of staff told us, "I have to get carers to show me every single person to ensure they are the right person before I administer their medicine". We saw people were administered their medicines in a caring manner. However, we saw the lunch time drugs round started shortly after the morning one had finished. We spoke with a member of staff responsible for administering medicines. They told us they ensured there was the required amount of time lapse between people being given their medicines despite drug rounds taking so long to complete. Managers acknowledged drugs rounds took longer when agency nurses were unfamiliar with people

and the need to monitor these to ensure people were getting their medicines on time. We saw the room where medicines were stored was cluttered and disorganised. When we returned to the home briefly on 5 February 2016, the clinical lead told us they were implementing daily and weekly audits of people's medicines following our feedback. They told us, "We've taken on board everything and we will do everything we need to do".

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Chief Operations Officer explained how permanent staff were recruited to the home and that new staff had the appropriate employment checks before they started work. We looked at three staff files. We saw all of the required checks were in place with the exception of one person who had two character references instead of one from a previous employer. Staff we spoke with told us all the required checks had taken place before they commenced working at the home.

We had received concerns about the cleanliness of the home. We shared these with Telford and Wrekin Clinical Commissioning Group (CGG). They advised they had carried out an infection control audit of the home and the provider had developed a service improvement plan as a result of the audit. The clinical lead at the home had carried out their own audit in December 2015 and no significant concerns were identified. During the inspection we detected an unpleasant odour in the main lounge but saw a domestic member of staff cleaning the carpet and the odour subsided during the course of each day. An unpleasant odour was also detected in some bedrooms we went into. We found sluice rooms were clean but were unlocked. One member of staff told us, "Some mornings it is horrendous, you can't find gloves, pads and aprons. They seem to disappear". We saw gloves and aprons were available but not always at the point of care, for example in people's own rooms. No paper towels or liquid soap were available in a communal toilet on one unit despite a person receiving barrier nursing. This is when extra precautions have to be implemented to prevent the risk of other people becoming infected. Training records showed that not all staff had attended training in infection prevention and control and many others were out of date. Most people we spoke with during the inspection were happy with the cleanliness of the home. One relative told us, "I find the cleanliness of [name of family member]'s room and the home very good. The domestics do a damn good job". Another relative shared concerns with us in relation to the home's cat and an incident concerning a potential infection control issue. Following the inspection the CCG carried out a further audit and advised us they had identified some poor standards of hygiene including poor documentation. They also observed some high risk practices in relation to cross infection within the home. Managers have been requested to complete a service improvement plan identifying the actions to address the audit findings together with timescales for completion. At the request of the new manager, training in infection prevention and control has since been arranged with the Telford and Wrekin CCG.

Requires improvement

Is the service effective?

Our findings

We saw that staff gained people's consent before supporting them with their care and respected their requests. Staff were able to share examples of how they sought people's consent. One member of staff said, "We ask them first". They told us they always introduced themselves and said if someone declined help they would try again later with the person. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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. We saw that the process for making decisions in people's best interests and assessing their capacity to make decisions was not always followed correctly. For example, some people's relatives had signed consent forms when people's capacity had not been assessed or where they had been assessed as lacking capacity. No documentary evidence was available on a person's file whose relative had power of attorney to make decisions within their powers on the person's behalf. Managers told us there had been no best interest meetings held recently but these had been held in the past. Our discussions with staff showed they had a limited knowledge and understanding of the MCA and Deprivation of Liberty Safeguards (DoLS) and not all staff had received training in this area. We saw DoLS applications had been made to the local authority for a number of people and were awaiting assessments. We found that a DoLS application had not been made for person who had been identified as lacking capacity and restrictions were in place that included a sensor mat in their room and a combination lock on their unit door. Their care plan stated, "A DoLS has been requested". However we were not able to see documentary evidence that it had been requested and managers confirmed an application had not been submitted. Therefore, this person was at risk of being unlawfully deprived of their liberty and their rights had not being protected.

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

People's views about the skills of the staff were mixed. One person told us, "The [staff] are very good and generally their attitude is very good". Another person said, "They're definitely not skilled enough. They can be quite rude". A relative told us that "agency staff don't appear to be as good as the regulars".

We spoke with staff about their training opportunities and feedback was varied. Three staff, that had worked at the home for a number of years, told us they were provided with good training opportunities. They said they felt they had the skills and knowledge to carry out their work. They told us their essential training was up to date and had also been supported to obtain professional qualifications in their work. However, new staff told us they had not received a formal induction to their work or received training. One member of staff told us, "I was just shown around the home and shown what to do by the seniors". Another member of staff said, "I've been here six weeks now and received nothing". Staff told us that they had opportunity to shadow other staff but this was difficult to manage at times due to the inconsistency of regular staff on shifts. One member of staff told us, "If we are short staffed it doesn't happen". A new member of staff told us after just two days induction they had been deployed to a wing they had not worked on and had an agency member of staff with them who had not worked at the home for a few months. They told us they were confident in their skills but they did not know any people. An agency member of staff told us they had last worked at the home a number of months ago and did not know all the people they were expected to support. We were told each employee was provided with a handbook and received an induction that included looking at the organisation's policies and procedures. Managers advised that they received a profile of training undertaken for agency staff so they are aware of training completed through the agency.

We were shown a copy of the training matrix which is a tool used to log staff names and the training completed and date. We were told this was out of date and did not include the new staff recently employed. Records showed that some subjects had not been refreshed often enough to ensure that staff knowledge was up-to-date. Not all staff had received training in areas such as the Mental Capacity Act (MCA), safeguarding, infection control and manual handling. It showed that staff training was not always up to date or had been completed. We saw some additional training certificates that needed to be added to the training

Is the service effective?

matrix. We were then given another matrix which showed all key training such as infection control, moving and handling and safeguarding was booked for different months throughout 2016 and included the new staff. Therefore we could not be assured that people were supported by staff whose knowledge was up to date and in line with best practice.

Most staff we spoke with told us they felt supported in their work by most of the management team. They said they had opportunities to meet on a one-to-one basis with a line manager to discuss their working practice but frequency of meetings varied. Managers acknowledged that not everyone had received one-to-one meetings on a regular basis. None of the staff we spoke with said they had received an appraisal of their work and performance. Staff told us they attended staff meetings but these were infrequent. Minutes of the last staff meeting held in November 2015 showed staff were able to share any areas of concern. We saw short 'flash' meetings were held each morning with a manager, nurses and senior staff to discuss a number of areas including admissions, assessments, external appointments, accidents, wound care and staff absence.

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 are called the Deprivation of Liberty Safeguards (DoLS). Staff were not aware of people that were being deprived of their liberty. One member of staff told us, "We are not sure who is deprived." Three other staff told us they were not aware of any restrictions on people. We saw that some people were restricted. We saw combination locks were fitted to unit and external doors restricting people's freedom of movement around the home and ability to leave the home should they wish to.

People we spoke with generally felt their health needs were being met. They said they had access to other healthcare services when required. During the inspection we saw managers sought advice from a health professional following concerns raised by staff about the deterioration in a person's health. One person said, "The eye surgeon came here to see me. The home organises everything for me". A relative told us they were always kept informed of any changes to their family member's health needs. Another relative told us they had not been provided with any updates following their family member's recent admission to the home and would welcome this. People had access to GPs, opticians, chiropodists and other health professionals in order to maintain their health. We saw that people's health appointments were recorded in the diary held in the main office. Staff gave examples of how they supported people to maintain good health. One member of staff told us, "If I notice a person is chesty or is in pain I will tell the nurse." They said they had supported people to medical appointments in the past. Another member of staff said, "I encourage people with personal hygiene, eating and drinking. If we notice anything we let the nurse know".

However, we found advice provided by health professionals had not always been fully actioned. For example, one person had been assessed by a physiotherapist because they wanted to get out of bed and a number of recommendations had been made. Records showed and discussions held with managers showed that not all recommendations had been acted on. Staff were not aware that a person required fortified drinks following advice from a dietician. We saw that people were weighed in line with the frequency identified in their care plan. However, records did not always show that people were repositioned in line with the identified frequency. This meant people may be at risk of their skin breaking down.

People told us the food provided was generally good and they were given choices. One person said, "The food is beautiful". Another person told us, "The food is marvellous. It's always hot and well presented". One person said, "I'm not a fan of the food here but I wouldn't put that as a mark against them. I have enough to eat and a choice of breakfasts and I can eat in my room if I want to". A relative told us, "The food is really good here, you can't fault it". They confirmed their family member received their meals according to their assessed needs and preferences. We saw two people were offered breakfast close to lunch being served.

We observed lunchtime in two lounges. In the main lounge the television was switched off and music put on which people appeared to enjoy. Tables were not laid in the dining area and very few people were encouraged to move to the dining tables. There were not enough over-chair tables to cater for everyone sitting in the lounge chairs. We saw one person asked to eat their lunch off a coffee table which was too low and made the person sit awkwardly. This meant people's experiences of mealtimes may not be

Requires improvement

Is the service effective?

pleasurable for them. Some relatives attended at lunch time to support their family member with eating. In both lounges we saw people were provided with a choice of food and those who required assistance to eat were supported appropriately. We saw people were offered a choice of cold drinks at mealtimes and during the day however, drinks were not always within people's reach for those who remained in their rooms. We saw there were drink dispensers and glasses for people to help themselves to drinks in the lounges. A twilight shift had recently been introduced from 4pm to 9pm whereby a member of staff provided drinks and food to people, which had proved to be sucessful.

People's nutritional and hydration needs were not consistently met. One person's records had a diabetes care plan in place that instructed staff to put sweeteners in hot drinks. We saw the person was given sugar in their hot drinks. Staff we spoke with were not aware of this or that another person's drinks should be fortified as recommended by a dietician. One person told us they had been given a certain drink on two occasions that they should not have due to the specific medicine they were taking. We spoke with the chef who worked for an agency. They told us they had not worked at the home for a number of months but had been provided with a list of people's dietary requirements. We saw the main meals were prepared and supplied by an external organisation and heated up before being served. People's dietary needs were recorded in their records and a quick reference guide was made available for staff. However some people's records about their dietary requirements were contradictory. For example one person's records stated, "Normal diet" whilst the care plan inside stated they were on a pureed diet. We saw the person eat a pureed diet with assistance from staff. The monitoring of people's food and fluid intake was inconsistent. We found the specific food people had eaten was not accurately recorded on their food charts. We saw a number of fluid charts had not been totalled up to show how much fluid people had. Inconsistent record keeping meant it was difficult to see if people were being offered sufficient amounts of food and drinks in line with their assessed dietary needs. The management team acknowledged these shortfalls and advised that recording issues had been identified and discussed in a recent senior staff meeting held.

Requires improvement

Is the service caring?

Our findings

We observed people's privacy and dignity was maintained with the exception of two occasions. However, staff took immediate action as soon as they were able to in order to preserve each person's dignity. A relative shared concerns with us about their family member's dignity being compromised on occasions due to staff not managing their continence needs effectively resulting in them lying in wet bedding. Similar concerns were also raised with us by a member of staff who told us of an incident where they had found a person "dripping of urine" a couple of weeks prior to this inspection. We checked their daily records and found nothing had been documented when the person had received continence care. Staff also told us that on occasions there was a delay in attending to people's personal care needs due to staffing numbers. We were told there had been issues in relation to continence assessments not being completed and continence products were now ordered at the point of people being admitted to the home and had been discussed in a staff meeting. We saw continence products were available and a list of products used by each person. Staff gave examples of how they respected people's privacy and dignity. These included, closing doors when people were using the toilet, making sure curtains were closed when delivering personal care and keeping people covered up. Managers told us staff did not currently receive training in privacy and dignity but this was promoted in discussions with them. They told us they were looking to provide 'dignity champions' shortly. A dignity champion is someone who acts as a role model to other staff and committed to taking action to create a system that has compassion and respect for people using services.

Staff gave examples of how they communicated with people who had difficulty expressing their views. These included, being patient, listening carefully, using pictures and simple phrases. We saw people's communication needs were recorded in their records. One person's records identified they used picture cards with written words to help them communicate as English was not their first language. We saw the cards were located in the person's bedroom and staff were not observed using them with the person during the inspection. We saw it was difficult for the person to communicate their needs with staff. Records showed that one person wore hearing aids but these had been misplaced some months earlier. The person told us, "I don't have a clue where they are". We saw a health appointment had been arranged to address the situation shortly to ensure the person had the necessary aids to help promote their communication. People told us they were able to choose their own clothes and where they wanted to spend their time. We saw people were encouraged to have personal possessions in their rooms. Staff gave examples of how they involved people in their care. Although people appeared well kempt on both days of the inspection we found gaps in people's welfare records in relation to their personal care needs being met. One person told us at 11am that they'd had their breakfast but had not had a wash which was reflective of their records we saw. One relative told us at times their family member's finger nails were dirty but this had improved following discussions with the management team.

Overall people shared positive views of the care they received and the positive attitude of the staff. One person who had recently been admitted to the home told us, "I've never experienced such a lovely atmosphere, patience and care". A relative told us they were happy with their family member's care and where they had previously experienced issues these had been addressed. One member of staff said, "This is my second home and second family. It is hard work and mentally draining but I have my dream job". Staff demonstrated a caring attitude during discussions with us and we observed staff to be kind and sensitive in their approach with people. However, staffing levels and their deployment did not provide staff with opportunity to spend meaningful time with people. One person told us staff did not have time to sit and talk with them as they were, "far too busy". With the exception of the activities co-ordinator, on occasions staff were less responsive to people's needs interacting only when carrying out care tasks. For example, when a person required assistance with moving or eating. One person said, "They're so kind; they're really caring". Another person said, "All I know is that people have been kind to me and do what they need to do". One relative told us, "Most of the younger care workers are lovely – I can't fault them". Another relative commented, "The staff are lovely". We saw a member of staff comforting a person who was distressed. They were patient and calm and listened to what the person was saying and reassured them. We saw other staff provided reassurance to a person who was demanding to go out for a walk. They accommodated the person's requests as soon as they were able to and provided reassurance to the person throughout.

Requires improvement

Is the service caring?

Staff gave examples of how they encouraged people to maintain their independence. These included, keeping people up to date with current affairs, trying to encourage people to mobilise and doing as much as they could for themselves by giving guidance. We saw staff supporting people with their mobility and saw staff encouraging and reassuring them in a kind and respectful manner. We saw relatives and friends were able to visit the service without any restrictions. Managers told us they, "Tried to actively engage with people's relatives". Several visiting relatives arrived during the inspection and were welcomed by name. Many involved themselves in the life of the home, especially when supporting their family members during mealtimes.

Requires improvement

Is the service responsive?

Our findings

People's care was not planned and delivered effectively to meet their individual needs. Most people we spoke with told us they had not been involved in planning or reviewing their care. We saw that initial assessments had been completed for people whose care we looked at in detail. Care records for people receiving respite (short-term) care contained minimal information. These and others sampled had not always been updated to reflect the most current information about people's needs; which meant people were at risk of receiving inappropriate and unsafe care. For example, changes in people's mobility had not been reviewed and updated. One person's surname was incorrectly used throughout their care plan. Some plans did not include risk assessments or detail how people's care needs should be met. We found staff were not always aware of people's needs or the support they required. For example, people's mobility needs. Some people's records were contradictory. For example, one person's care records stated they were fully continent but their welfare records stated the person's continence product had been changed. These inconsistencies placed people at risk of not having their care needs met particularly when people were supported by agency staff that were not familiar with their needs and preferences. An agency member of staff told us they were not provided with sufficient information about people's health conditions. They said, "There's a lack of consistency in care". Managers told us they were in the process of changing over to new care planning documentation. Staff told us they were verbally informed of changes in people's needs at staff handover. One member of staff said, "We have to remember everything as the handover only has their person's name and room number. We don't have time to read care plans only fill in daily records." The new manager acknowledged the need to provide care more tailored to people's individual needs and preferences.

We observed people being given choices. For example, some people were asked where they would like to sit, what they would like to drink and what they would like to do. Staff were able to give examples of how they promoted choice with people. We saw that one person's care plan identified that they liked to get up around 8:00am. However monthly welfare records showed the person usually got out of bed much later than this time.

Not everyone had been involved in developing or reviewing their care plans. We saw some consent forms had been signed by people's relatives. One relative told us they had read their family member's care plan. A relative of a person new to the home told us, "We've had no phone calls or feedback" in relation to their family member's care.

People's cultural needs were considered and respected. We saw that people's religious beliefs were recorded. One person told us they were supported with their chosen faith and attended church and had visits from a priest. We saw that one person had participated in listening to music from their country of origin.

People told us they enjoyed the activities. One member of staff said, "The residents have lots of activities, some choose not to join in". We saw a full-time activities co-ordinator was employed and worked at the home during weekdays. People were complimentary of them and the activities they provided. One person told us, "[Name of activity co-ordinator] is a great asset. She's taken me out several times". Another person said, "She has sessions where she asks questions and throws it open to the floor". A relative told us, "The activities organiser is brilliant and very hardworking. The entertainment provided has been marvellous". People felt more activities needed to be provided during weekends. We saw people engaged in both group and individual activities. For example one person enjoyed listening to music on the iPad. Another person chose to play cards. We saw another person reading the newspapers. Some people engaged in activities they enjoyed whilst they were in their rooms.

We saw activities were displayed on a board and these detailed the activities on offer. We spoke with the activities person who told us that when people came to the home they spoke with them and their relatives to find out that they were and what they liked to do. They showed us an iPad containing video messages from relatives for people at the home when they could not be present on special days such as birthdays. We also saw people had been filmed participating in activities such as dancing. These were often shown to the people's relatives to demonstrate people's engagement. The activities co-ordinator was enthusiastic about their work and told us they considered each person as an individual. They shared a copy of a newsletter that contained photographs of outings such as a trip to a local museum and a garden centre. We saw links with the local community were encouraged. A local choir

Requires improvement

Is the service responsive?

and children from the local school had been to the home to provide entertainment for people. We saw a number of people spent time in their rooms. Some people had their television or radio on. One person told us they enjoyed listening to classical and they had their classical music on. Another person was sat colouring. One person said, "I don't partake in the activities. I like a good book and listening to the radio." One person told us they received a regular manicure from a visiting therapist. Managers told us they had drafted an easy to read residents' guide that contained information for people about the services available in the home such as the hairdressers.

People knew what to do if they were not happy about the service provided. People shared mixed views about their experiences. One person said, "I have to keep complaining all the while which isn't right. Another person said, "I've got nothing to complain about". One person said, "I'm well fed, I'm kept warm and my room is comfortable. There's nothing really I can complain about. If I did I would report it to a member of the staff or I'd ask to speak to the manager".

Staff told us that if a person approached them about a complaint they would refer it the management or a nurse. One relative told us they had a number of concerns they had planned to raise with the manager on the day of the inspection but shared these with us. Concerns included staffing levels, lack of attention to their family member's oral hygiene, continence management and a lack of personalised care. They told us they had raised similar issues before and yet they felt the need to raise the same issues again. We saw people had access to information in the reception area about how to complain but this information was out of date. We looked at the complaints log and saw that complaints were acknowledged, investigated and a response sent of the provider's findings. Two complaints were still in progress. We saw evidence of a complaint in relation to one person whose care we looked at in detail, however the provider had failed to follow safeguarding procedures. We were told the allegation made had been investigated internally and there was no evidence found to support the allegation made.

Inadequate

Is the service well-led?

Our findings

We found the lack of strong and consistent leadership underpinned many of the failings we identified during this inspection. Poor communication systems, the lack of co-ordinated team work and inconsistent staffing meant managers and those in charge of the home were not always aware of what was happening in the home. For example, managers were unaware of two recent adverse incidents that had occurred because although these were recorded they were not reported to them. One member of staff told us, "We don't get informed of things that are happening". They told us there was a lack of communication and involvement from managers to carry out their work effectively. They shared an example of one person returning from hospital and they were unaware of the person returning.

The service had been subject to a large scale investigation led by the local authority following a number of safeguarding concerns. Multi-agency meetings had been held and the home had been subject to scrutiny by a number of external agencies. Although improvements had been made and the service removed from the investigation in December 2015, improvements had not been sustained as identified by further visits undertaken by external agencies and our inspection.

Risks to people had not always been identified or effectively managed. For example, we saw a number of people's care plans and risk assessments had not been reviewed to reflect people's changing needs. This potentially placed people at risk of receiving unsafe care. Staffing levels had not been regularly reviewed to respond to people's changing needs or incidents that had occurred. We saw examples of poor and inadequate record keeping. Staff were not consistent with recording people's medicines, food and fluids or the personal care that they provided. These shortfalls had not been identified or monitored by the management team. The management team told us during feedback that they had arranged for staff to attend training in recording and reporting.

Staff meetings were held but not all staff had received a formal induction to their work or received regular one-to-one meetings to discuss their work and some staff training was out of date. Therefore there was a risk of staff not understand their roles and responsibilities.

We saw there were processes in place to monitor the performance of the service but these were inconsistently applied and were not effective in securing service improvements. Audits had failed to identify the concerns that we found during the inspection to include ensuring accurate records were being maintained and that people's needs had been adequately or accurately assessed and reviewed. We were told audits for January had not been completed. The last quality audit completed in December 2015 showed only two people's care records were sampled for the purposes of the audit and the medicines were audited for four people. There were no actions stated where shortfalls were identified. We saw the most recent medicines audit showed gaps were identified on two of the four people's MAR charts sampled but did not state the action taken. There was no system in place to ensure a sufficient stock of medicines was available. There was a process in place to ensure incidents were monitored to identify any trends and prevent reoccurrences where possible. However, we found managers were not always made aware of incidents in a timely manner as identified during the inspection and not all potential safeguarding incidents had been reported to external agencies as required. This meant that the provider had failed to maintain oversight of the quality of service they were delivering. The service improvement plan completed following an external infection prevention and control audit had not secured improvements in the standards of hygiene and infection control.

These issues were a breach of Regulation 17 HSCA of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to gain people's views for example through meetings held to include residents' meetings and staff meetings. One person told us, I've been to a residents' meeting and we were asked if we had any concerns and if there were any gaps in our care". A relative told us, "The meetings can get quite heated." Another relative told us they attended the meetings and felt views shared were listened to. We saw copies of the minutes from meetings held in September 2015 and November 2015 and some issues raised had not been actioned. For example a pictorial menu was to be produced, however, we did not see this in place and the request to change a meal option had not been changed. When we returned to the home briefly on 5 February 2016, we were provided with a copy of the minutes of the meeting held on 4 February 2016.

Inadequate

Is the service well-led?

Minutes showed people were introduced to the new manager, brief findings from our inspection were shared, and a staffing update was provided in addition to meals and care reviews. We saw people were given the opportunity to contribute to the meeting. Satisfaction questionnaires had been distributed to family members in May 2015 and staff in February 2015. Feedback was mixed. We were told further surveys had recently been distributed to staff and they were awaiting feedback. Although the previous staff survey included staff comments in relation to how they considered improvements could be made, there was nothing documented in relation to action taken and timescales.

We asked the Chief Operations Officer about the provider's visions and values, although they were able to explain these, staff were not able to tell us what these were. Concerns were raised about the organisation of the home and staff having to wait to be directed. One member of staff told us, "The carers are trying their absolute hardest here but this is one of the worst homes I've worked in in terms of organisation".

There was no registered manager in post. The previous registered manager had left employment in September 2015. People had experienced changes in the management team over the last 12 months. A new manager and deputy manager had commenced working at the home two weeks prior to this inspection. The manager told us they were going to apply to be registered with us. The Chief Operations Officer was based at the home and had been managing the service since September 2015 with the assistance of a support manager.

Not everyone we spoke with knew who the new manager was. Those who did spoke very highly of them. One person told us, "I really like the new manager. She's the right sort of person to have. She takes the time to come and see me and listens to me". A relative said, "There's been so many changes in management but I'm confident [name of new manager] can make the required changes. I think the care will be very much improved now". A member of staff said, "The new manager is nice, calm and approachable. She's a good person to talk to and gives you the answers". Another member of staff said, "The new manager is doing a stirling job, they have a good job ethos, good standards." Discussions held with managers showed they were committed to improve the quality of the service provided and fully acknowledged our findings. The new manager shared improvements that they wanted to make. These included recruiting permanent carers and nurses and improving the lifestyles of people living with dementia. We observed the new manager to be open and transparent about where the home is and their vision for the future. They told us that they planned to meet with people using the service, relatives and staff to discuss moving the service forward and was clearly committed to making improvements. They said, "The residents are my priority; I have their best interests at heart".

The management team acknowledged the shortfalls we identified and immediately developed an action plan for improving the service following our feedback after the first day of the inspection. The provider told us they would not be accepting any new people to the home until they were confident they had addressed the issues identified. When we returned to the home briefly on 5 February 2016, we saw an audit of welfare checks had commenced. Following the inspection a meeting was held with the provider and a number of external agencies to discuss the concerns identified. The provider shared their action plan to address the identified concerns in order to improve the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured that people's consent had been gained and their capacity had been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured that people were protected from the risk of harm and the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that there were effective systems and processes in place to assess the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured that there were enough staff on duty or deployed to meet people's needs.