Premiere Health Limited

Cann House Care Home

Inspection report

Cann House
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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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 with six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within the 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.

The service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no longer 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 key questions it will no longer be in special measures.

The inspection took place on the 20, 21 and 26 September 2016 and was unannounced.

Cann House provides nursing care and accommodation for up to 61people. On the day of the inspection 56 people were using the service. Cann House provides care for people with physical frailty, illness or disability.

The service had a registered manager in post. 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.

Prior to the inspection the Commission had received a number of concerns. These included, issues relating to staffing levels, the cleanliness of the environment and the handling of complaints.
We were also told people were at risk as they were not always provided with their prescribed medicines, and needs in relation to skin care, continence, and diabetes were not being met.

At this inspection we found people were not always protected from risks associated with their care because risk assessments were not always in place to provide guidance and direction to staff about how to keep

people safe. Known risks in relation to people's mental health were not always documented as part of their plan. Action had not been taken when people's mental health deteriorated, which meant people did not receive the help they required.

People's medicines were not managed, administered and stored safely. The service had introduced a new medicines system, which showed a large number of missed medicines. It was not possible to ascertain if these were actual errors or a problem with the new system and training of staff. Some people had not received their prescribed medicines as required. The management of medicines stock was poor. We found large quantities of stock unsafely stored, which could not in all cases be accounted for. Medicines were not always stored at the correct temperature.

Although infection control policies and procedures were in place, some practices did not protect people from the risk of infection. We found the treatment room to be cluttered and unclean. Bins for the disposal of medicines were dirty and in some cases broken and still in use. Sluice rooms were not lockable and medicines pots had been washed using paper towels and left draining in people's bathrooms. Insufficient cleaning and poor maintenance of medical equipment could increase the risk of cross infection.

People did not always have sufficient detail in care plans care plans in place to provide guidance and direction to staff about how to meet their needs. Plans to support people with needs associated with diabetes and pressure care did not help ensure appropriate, effective or responsive care. People's changing healthcare needs were not always referred to relevant healthcare services promptly to ensure they received appropriate care and treatment.

Care plans did not always provide detail about how to meet people's individual dietary needs. Documentation, which was being used to monitor how much a person was eating and drinking was inconsistently completed, meaning it was not clear if the person was eating and drinking enough.

The provider did not have effective systems and processes in place to help monitor the quality of care people received. Safeguarding procedures had not been followed as required, which meant people remained at risk. Incidents were not always escalated appropriately to ensure people were safe. People were at risk because gaps in records and errors in relation to medicines had not been identified and addressed. The outcome of incidents, investigations and complaints were not always used to drive improvement across the service.

Staff and other agencies said they felt staff were sufficient in numbers. However, people said staff were always rushed and did not have any time to spend just sitting and chatting with them. Some people said this made them feel unwanted and lonely. People said they often had to wait while staff supported people with more complex needs, and this could mean waiting until late morning to get washed and dressed. People and relatives said staff did their best, were kind and caring, but just too busy to give any extra. Relatives expressed concern that people were reluctant to use call bells as they didn't want to disturb the staff who they knew were very busy.

The provider had a complaints policy, however, people did not always feel their complaints were listened to or taken seriously. Complaints were not always used to improve the quality of the service.

We observed some positive interactions between people and staff when direct care was being provided. However, we saw staff rushing around and not always acknowledging people as they passed them or entered their rooms. Consideration was not always given to people's privacy and dignity when personal care was provided and people's personal information was not always protected.

We received mixed feedback regarding the leadership of the service. Other agencies said the registered manager was always open and communicated any concerns appropriately. However, we were told the registered manager did not always demonstrate a consistently positive and professional attitude. We saw the registered manager had considered ways of improving the service. For example, they had introduced a new medicines and care planning system to help improve the quality of the service. However, there was no plan in place to consider staff feedback and to monitor and address issues relating to the system during the implementation stage.

Staff undertook a range of training appropriate to their role. Staff said they had formal supervision but did not always feel listened to or valued by management. Some staff said they felt this had resulted in low morale within the staff team, which they believed would impact on the quality of care provided to people.

Staff undertook safeguarding training, and a safeguarding policy and procedure was in place. However, some of the staff were unfamiliar with the procedures for reporting safeguarding concerns. Staff were not always clear about how to report safeguarding concerns outside of the organisation.

The registered manager understood their role with regard to the Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards (DoLS). People's capacity had been assessed in relation to medicines and living in the home. Capacity had not been assessed and documented in relation to other areas of people's care and lifestyle. We did see staff asking for people's consent before care was provided.

People spoke highly of the activities coordinator and many said they enjoyed the group activities organised in the home. However, some people said the group activities did not interest them and were not available during the evening and weekends. Some of the people who spent most of their day supported in their bedrooms said there was little available to help them occupy their time.

The registered manager had recruited nursing assistants to support qualified nursing staff and to reduce the use of agency workers. They had also been part of a city wide initiative to enhance the training of nursing assistants and to develop this role for the future. One staff member said, "The registered manager was very supportive of me when I did my nursing access course".

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always have risk assessments in place to mitigate risks associated with their needs. The provider had not in all cases taken appropriate action to keep people safe.

People's medicines were not stored, administered and managed safely.

Staff did not always follow safe infection control procedures.

People told us there were not enough staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People's healthcare needs were not always monitored to ensure any changes or concerns could be acted on promptly. People's changing needs were not always referred to relevant agencies to ensure they received the correct support.

People told us the food was usually good, but sometimes the choice and quality varied. The recording of people's food and fluid intake was not in all cases sufficient to ensure they had their nutritional and hydration needs met.

People were assessed in line with the Mental Capacity Act 2005 when it was considered their rights and liberty could be restricted. Staff asked people for their consent before providing care, however, records did not demonstrate capacity assessments had been considered for all areas of care.

Staff did undertake training relevant to their role and the needs of people they supported.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel listened to or in control of their care.

People said staff were always rushed and this sometimes made them feel lonely and as if they did not matter.

People's privacy, dignity and personal information was not always protected.

People's religious needs were taken into account when planning care and relatives were welcomed into the home without any restrictions.

Is the service responsive?

Inadequate

The service was not always responsive.

People's needs were not always known by the staff supporting them. Care plans were not personalised and did not provide staff with sufficient information to respond effectively and consistently to people's needs.

Although there was a complaints system, the provider did not always listen fully to people's views, investigate their concerns thoroughly, or consider ways to improve practice.

People were able to benefit from group activities, however activities were not always personalised and did not always take into account people's particular needs or interests.

Is the service well-led?

Inadequate

The service was not well-led.

Staff said they did not always feel supported or able to raise their concerns, resulting in low staff morale, which impacted on the quality of care provided.

The impact on people's health and safety had not been monitored when new systems were implemented in the home.

The provider did not have effective systems and processes in place to monitor the quality of care people received.

The provider did not have an accurate overview of incidents in the home. The outcome of incidents, investigations, complaints and concerns were not always used to drive improvement across the service.

Cann House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 20, 21 and 26 September 2016 and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a registered nurse.

Before the inspection we reviewed information we held about the service. We had received a number of concerns in relation to people's care, the management of medicines and the handling of complaints. We took this information into account when planning the inspection. We reviewed notifications sent to us by the provider. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 25 people who lived at Cann House, 10 relatives, the registered manager and 17 members of staff. We also spoke with five health and social care professionals, which included three social workers and two professionals employed by the local authority and NHS to review people's support arrangements and care practices within the service.

The specialist advisor spoke with 8 staff about the management of medicines as well as a GP who was visiting the service. They also looked at the medicines records of 49 people who were using the service.

We looked around the premises and observed how staff interacted and supported people throughout the three days.

We viewed four staff files, training records and records associated with the running of the service including quality audits.

Inadequate

Is the service safe?

Our findings

Prior to the inspection the Commission had received information of concern that people's prescribed medicines were not always available or administered on time, there were poor infection control practices and staffing levels were not sufficient to meet people's needs or to keep them safe. Concerns had also been raised in relation to delays in taking action to manage risks associated with skin and pressure care. Some of these concerns had been investigated by the local safeguarding team and the provider had completed action plans to address substantiated concerns or areas of practice that had been identified as requiring improvement.

At this inspection we found one person had known risks associated with anxiety and depression. However, there were no risk assessments in place to support this person's needs or to direct staff on the action to take to address or minimise the risks. We found senior staff and management had not followed procedures to ensure this person's safety when a serious incident had been reported. The provider had failed to escalate the concern to external agencies and measures to protect the person concerned were insufficient to ensure they remained safe and protected. We raised our concerns with the registered manager at the time of the inspection about this person's safety and made an alert to the local authority safeguarding team. We also requested that the registered manager updated us on the action they had taken to ensure this person was safe.

People were not always protected from risks associated with their care. There was limited evidence of a structured approach to managing people's skin conditions and diabetic care. People's skin integrity was not always safely monitored to help ensure skin damage was prevented. For example, one person had a tissue viability assessment completed as part of their hospital discharge plan. We found this plan loose at the back of the person's file and the information had not been transferred into the support plan completed by the service. Staff were not familiar with or working from the plan provided by the hospital. The tissue viability plan stated the person required regular fluids to prevent any further breakdown of their skin. Systems were not in place to ensure an accurate record of this person's fluid intake. For example, staff said the person regularly refused drinks. It had not been documented when the person refused. Staff also said the person would drink from their own water bottle in their room and would have drinks given to them by relatives. This fluid intake had not been documented. We looked at the records of two people who had health needs associated with diabetes. Systems for recording and monitoring these people's needs were inconsistent and did not demonstrate people were being supported safely. For example, it was not possible to find a clear summary of one person's blood sugar levels. The recording of this information could not be found on the electronic system or in paper records. It was therefore difficult for us to ascertain if people with insulin dependent diabetes management were supported safely.

People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks. The provider did not take responsive action in order to keep people safe. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines was not safe. Systems for receiving, administering and storing medicines

were inconsistent and did not demonstrate safe medicines practice.

The home had two medications systems in place, one electronic system and one with MAR (Medication administration records) charts and paper records The system used for medicines depended on whether the person was staying on a temporary basis for rehabilitation or if they were in a long term placement. The hand held electronic system had been introduced three weeks prior to the inspection and the registered manager said they hoped it would be a safer way of managing medicines. However, we found a number of concerns relating to the way medicines were managed.

We found a large number of missed medicines recorded on the hand held system, for example, the medicines records showed 49 people had missed medication during August and September. One person had missed 36 medicines, another person had missed 29 medicines. The registered manager said these errors were a 'glitch' in the new system, and not real errors. This raised issues over identifying which were systems errors and which were genuine medicines errors. We found no audit or action plan to follow up on these recorded medicines errors. Some people told us they did not have their prescribed medicines available to them, for example, one person said they had a pain relieving medicine prescribed daily, but did not have enough available for the rest of the week. We spoke to the registered manager about this person at the time of the inspection and the lead nurse on duty was passed the information to address as a matter of priority. Another person had been prescribed cream for a pressure area. This had not been recorded as administered and although the medicine was in the home, the person had not received this as prescribed. This meant they were at increased risk of skin damage. We spoke with the registered manager about this person and they assured us the medicines would be prescribed as required.

The management of medicines stock in the home was unsafe. For example, we found large quantities of stock in the treatment room that could not in all cases be accounted for. Systems were not sufficient to provide clear information about excess or low stock or medicines that were needed.

Medicines were not in all cases safely stored. Some people's medicines were stored in their bedside cabinets. Although these were locked, checks were not completed to ensure they were stored at the correct temperature. Some medicines had been stored in a medicines fridge, however regular temperature checks had not been undertaken as required. This meant the quality of medicines requiring cold storage may not be maintained.

Staff were in the process of being trained in using the new hand held medicines system. Staff said they were not always able to access the hand held device to record information. This meant documentation was not in all cases up to date and accurate. For example, staff told us they would sometimes get called away to deal with another issue and would forget to input the information. Some staff were writing things down on scraps of paper in their pockets to put into the system when they could. We saw one staff member writing information on a paper towel as they were not able to get to a hand held device to input it. The induction of agency staff to the new medicines system was not structured. This posed a possible risk of medicines errors when untrained staff used the new medicines system. Agency staff were provided with a pin code to access the electronic system and to be a second witness for controlled drugs. As the pin code was universal for all agency staff it was not possible to track the person to follow up on any issues.

Medicines were not managed safely. The provider did not ensure medicines were available in sufficient quantities to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff wore protective clothing and people's laundry was handled in line with appropriate infection

control guidance. Most parts of the home were clean and odour free, however one corridor smelled strongly of urine. The registered manager said they were aware of this and systems were in place for domestic staff to clean the bedroom and hall in this area to help eliminate the odour throughout the day. This information was not documented in cleaning checklists and the smell of urine was strong in this part of the home throughout the inspection. The sluice rooms on each floor were not lockable, which meant people could be at risk from access to soiled laundry. Medicines pots were re-used without being thoroughly cleaned. We saw pots had been left to dry on paper towels in people's bathrooms with residue of medicines still visible. We saw some of the bins for the disposal of medicines were unclean and smelling. The lid of one bin was broken and still in use. Insufficient cleaning and poor maintenance of medical equipment could increase the risk of cross infection.

Systems were not sufficient to prevent and control the spread of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the three days of the inspection we saw consistency in the staff numbers, which included a qualified nurse, a team leader, four nursing assistants and thirteen care staff. The registered manager was also in the home as well as cleaning staff and a cook. Other agencies we spoke with said they felt there always seemed to be plenty of staff in the home but expressed concern about a heavy reliance on agency workers, who were not always familiar with the people they were supporting.

People told us the service was short staffed which meant staff did not always have time to speak with them or they had to wait a period of time to be assisted. Comments included, "They never get a chance just to sit and have a chat", "I didn't see anyone yesterday, it can be very lonely", "They are very busy, they have to see other people who need more help, god help us if we need to go to the toilet". Relatives said the staff always appeared rushed and some expressed concern that people's basic care needs were not always being met. One relative said their relative was hard of hearing, "The staff come to the door, ask quickly if she wants a cup of tea, and if they don't answer then they go away without leaving them one".

Some people said they were reluctant to use their call bells as they knew staff were very busy. Staff said they felt there were enough staff to keep people safe, but they did not have time to spend with people and recognised sometimes people had to wait to have their care needs met. Comments included, "Being short staff impacts on us a lot, we are tired and residents get upset too" and "It's very stressful when we are short staffed, you don't feel like you are giving all you can, it's hard to make an excuse when someone wants to just get dressed or go to the toilet." Other agencies expressed concern about the inconsistency of permanent staff and a heavy reliance on agency workers, who were not always familiar with the people they supported.
Staff told us they felt the call bell system was not safe. We were told after three minutes the system flashed and tone changed indicating an emergency, whether it is an emergency or not, and therefore staff could not differentiate between genuine emergencies and an unanswered call bell. We were told a staff member had been with a person when a potentially serious incident occurred. The staff member had rung the call bell for support but staff had not responded as they were so used to hearing the emergency tone.

The provider had not organised staff in sufficient numbers and skills to meet the need of all people using the service. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff undertook safeguarding training, and a safeguarding policy and procedure was in place. However, some of the staff were unfamiliar with the procedures for reporting safeguarding concerns. Staff were not always clear about how to report safeguarding concerns outside of the organisation.

People were protected by safe recruitment practices. Records evidenced all employees underwent the necessary checks prior to commencing employment to confirm they were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Information in people's care records regarding their health needs was very limited. For example one person's care plan said they had specific healthcare needs in relation to their skin. The plan did not provide any other detail or guidance for staff about these needs or how they should be met. Some people had treatment plans provided by the hospital as part of their hospital discharge and rehabilitation plan. This information had not in all cases been transferred into a plan for the home and was not always possible to locate by the staff providing care. Staff said they relied on daily handover notes and "getting to know" people when providing care. This raised concerns regarding consistency due to frequent changes in the staff team, high use of agency staff and staff comments that handover meetings were often rushed.

People's changing healthcare needs were not always referred to relevant healthcare services promptly to ensure they received the care they required. For example, daily records showed one person's mental health had deteriorated, and they were showing signs of very low mood and possible depression. However, their records did not show timely action had been taken to seek medical advice when this decline had been noted. Another person was displaying behaviours, which health professionals said could impact on their general health. These behaviours and dialogue between the staff, the person and their family had not been documented and no consideration had been given to the possible impact on the person's health and well-being. We shared our concerns with health professionals reviewing this person's care at the time of the inspection.

People's healthcare needs were not always monitored to ensure any changes could be identified and addressed. For example, one person had a treatment plan provided as part of a hospital discharge. The plan stated the person had high risks relating to pressure care and tissue viability, and would require close monitoring of their skin and fluid intake. Although monitoring forms were available we found gaps in recording and inconsistent monitoring of the person's fluids. For example, the records for one day showed the person had received no fluids. Staff said this was not accurate as although the person had declined drinks from staff they had been given a bottle of water to drink independently and also received drinks from a relative. This information had not been documented, which meant we were unable to ascertain if the person's needs had been met. We spoke with healthcare staff overseeing this person's care and they felt the monitoring and recording undertaken by the service was insufficient to provide a clear picture of the person's progress or to pick up on any significant changes in the person's health and well- being. We spoke to the registered manager about this person and they told these us these issues would be addressed as a matter of priority.

People's care arrangements were not personalised and did not provide those caring for them with sufficient information to understand and respond effectively to their needs. People's changing healthcare needs were not always monitored or referred to relevant healthcare services promptly. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said the food in the home was "usually good". Some people said they had a choice and we saw pictures in the main dining room of menu options for the day. We saw these pictures were not always

accurate and did not reflect the meals provided on the day stated. However, some people who received most of their care in their bedrooms said meals and drinks were often cold by the time they received them, and they weren't always informed of any choices available. One person said they could choose to have a cooked breakfast, another said they did not know this was available.

Some people ate in one of two dining rooms, either independently or supported by staff. Others either chose or needed to have their meals in their bedrooms. We saw most of the food was well presented and hot. However, thought had not been given to the presentation of food for people requiring a pureed diet. Pureed meals looked unappetizing and were not presented in a way that helped the person know what they were eating.

Cold drinks were available for people to help themselves to in the lounge. Hot drinks and snacks were provided at regular intervals throughout the day and evening. People's likes and dislikes and any particular food allergies were recorded and understood by the kitchen staff.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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 as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive.

We observed staff asking for people's consent before providing care and treatment. For example, one staff member asked if a person was happy for them to administer their morning medicines and checked the person understood and was happy with how they would be given. People's capacity had been assessed in relation to them living in the home and having their medicines administered. However, care plans did not record capacity in relation to day to day decision making or evidence that a best interest process had been followed by staff.

People can only be deprived of their liberty in order to receive care and treatment, which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes are called the deprivation of liberty safeguards (DoLS). The registered manager was aware of this process and had made applications for authorisations under DoLS when they were required. Two DoLS applications had been authorised and others were logged with the local authority supervisory body awaiting assessment.

Staff said they had lots of opportunities to undertake training relevant to their role and this training was updated when required. In addition to mandatory training such as food hygiene, health and safety and safeguarding, staff also undertook role specific training such as a nursing assistant course, pressure care and emergency treatment training. New staff employed by the provider had undertaken a thorough induction when they started work, however, induction of agency staff was not structured or thorough, particularly in relation to new systems such as medicines and records. New staff said the systems were very confusing and difficult to learn. Comments included, "The senior staff will show us how to log on and then just stay on a bit to see we are ok with it".

We received mixed feedback from staff about the support they received to fulfil their role in the home. Some staff said they felt well supported by management and could always ask for help if they had to deal with a difficult situation, however, others said they did not always feel supported or listened to. Comments included, "Staff meetings are a time to be spoken to, not with". All staff said they had regular formal supervision and annual appraisals to discuss their role in the home and reflect on practice.

Requires Improvement

Is the service caring?

Our findings

People's dignity and privacy was not always respected. Some people shared a bedroom with another person in the home. Privacy screens were not always available to help ensure people had privacy when care and treatment was being provided. We saw staff did not always close bedroom or bathroom doors when providing personal care, and some staff entered people's bedrooms without knocking or acknowledging the person when they walked in. Bedroom doors had 'Do not disturb signs' but these were not being used for all people receiving personal care in their rooms.

The provider did not always ensure people's privacy and dignity was respected and protected. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the staff were kind and caring. However, all the people we spoke with said the staff were always rushed and didn't have chance to just sit and have a chat. Comments included, "They do their best, they are always so busy and rushed". Some people said they felt staff didn't have time for them if they were able to do things for themselves and said made them feel "unwanted" and "Not listened to". One person said "If you are at the end of the corridor and able to get yourself up you may not see anybody all day, it can be a very lonely place".

We saw some positive interactions between staff and people when direct care was being provided. For example, one staff member supported a person with their morning medicines in their bedroom. They made sure the person was happy with their care and had friendly conversation while the care was being provided. A member of the cleaning staff was aware of one person's needs and their personality, they said "I always wait to clean their room to ensure I cause the least distress as possible. They are very independent and it's important to respect that." However, we saw staff were often very rushed and did not spend time sitting with people when care was not being provided. We saw staff rushing from one room to another not always smiling or acknowledging people as they went by. Staff said they felt there was a focus on tasks and said they knew they spent very little time just sitting and getting to know people.

We saw a number of people still in their night clothes at 11am. The staff said some people were supported by night staff to get dressed if they chose to get up early, but others had to wait for care staff to work their way around each room. One person said they had a friend who visited them late morning. They said they had been embarrassed to still be in their night clothes and had to turn the visitor away. Care records did not provide information about people's daily routines or times they preferred to get up or go to bed.

Consideration had been given to people's cultural and religious needs. The home had a chapel people could use if they wished and a service was held once a month. Arrangements were made for people to attend church services outside of the home if requested. The registered manager said they had contacted the local Jewish community to request appropriate support for a person in relation to their end of life needs.

Relatives said they were always made to feel welcome and were able to visit at any time.

Inadequate

Is the service responsive?

Our findings

Prior to the inspection we received information of concern about the handling of complaints. People told us they felt their complaints had not been fully investigated and they felt their concerns had not been listened to or respected by the provider.

At this inspection we found complaints were not always effectively listened to, resolved or used to improve the service. We spoke to the registered manager about complaints and looked at the complaints process. We saw complaints had been dealt with within the agreed timescale, and feedback on any investigations had been given to the complainant and other relevant agencies. However, the tone of some correspondence we looked at suggested the provider had not in all cases listened to the complainant or carried out a sufficient investigation of their concerns. For example, a person had made a complaint regarding their care and the environment whilst they had lived in the home. The provider's response to most of the areas of concern was to say they did not agree with the concern raised, without providing any evidence to the complainant of how they had come to this conclusion.

Some people said they did not know how to raise a complaint and others said they felt there was no point as staff were too busy to listen to them. A relative said they had a good response from the staff when they raised concerns, but felt the response and action taken depended on who you spoke to.

The provider did not effectively record, handle and respond to complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have sufficiently detailed care plans in place to provide guidance and direction to staff about how to meet their needs. Staff we spoke with were not in all cases familiar with the needs of people they were supporting. For example, one person had moved into the home for a short stay following discharge from hospital. The hospital notes said the person was likely to be very nervous and anxious. We saw this person was sat on their own in their bedroom. The location of the room and person's bedside chair meant staff could not easily see them and the person was not able to be reassured by seeing people pass by their room. Staff we spoke with were unfamiliar with this person's hospital discharge plan and were not able to tell us how they needed to support the person in relation to their anxiety and emotional well- being.

We looked at a person's plan, which stated they needed pressure relieving equipment for their skin. The plan did not state what this equipment was or how the staff would use it to support this person's needs. Another plan stated the person required total support with daily personal care needs, but did not describe to staff how the person needed or preferred this support to be delivered. The absence of this information meant care and support may not always be delivered consistently in a way people needed and wanted.

Staff said they felt information about people was limited and did not provide them with personalised information about people they supported. Comments included, "There is no information about the person, we just click to say personal care done, the electronic care system is shocking, staff don't document as they go so it's not always accurate".

People's daily care records were not completed in sufficient detail about the care being delivered. This meant we were unable to ascertain if people's needs were met in line with their care plans. Daily monitoring records were very brief and did not provide information about how people had spent their day. Reference was made to drinks and personal care given but no detail on the person, their mood or how they had responded. Staff told us one person was displaying behaviours in relation to their continence care. The staff said they recognised the behaviour could be problematic for the person concerned and could result in a deterioration of their health and well- being. However, the observations of staff had not been documented and there was no evidence of this issue being escalated to establish if any additional support was required. We spoke with healthcare professionals about this person's needs at the time of the inspection.

Inconsistency in systems and the way information was documented prevented staff from effectively responding to people's needs. People's care records were either documented on an electronic system or within paper files. Some of the paper records could not be found during the inspection. Some people had monitoring forms in their rooms for re-positioning and other information relating to moving and handling. However, some staff were not familiar with who had this information in their room and monitoring forms were not directly linked to care plans. We looked at the records of one person who had needs in relation to diabetes. We found inconsistency in recording between day and night staff. For example, the person's blood sugar levels had been recorded by one person on the electronic system and another within a paper file. It was not possible to find an accurate summary of the person's blood sugar levels. This inconsistency in recording could mean staff were not responding appropriately to people who had needs associated with diabetes.

People did not have care plans in place to provide guidance and direction to staff about how to meet their needs. Inconsistency in recording and the care planning process prevented staff from effectively responding to people's needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were very positive about the activities coordinator and some people said they really enjoyed the group activities organised in the home. One person said "We had someone bring in Owls for us to look at", and "The activities organiser is great, a really good addition to the staff". However, some people said they didn't enjoy the group activities and the evening and weekends could be very quiet with little to do. Some people who were mainly cared for in their bedrooms said they often didn't have anything to do during the day.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Systems and processes were not well established or operated effectively to ensure the provider was meeting the requirements of the Health and Social Care Act (2008). Effective governance was not in place.

A new care planning and medicines system had been introduced, which the registered manager said they hoped would reduce errors and improve quality of care. However, a plan had not been put in place to monitor these systems during implementation or to consider staff views in relation to the use of these new systems. For example, we found a high number of medicines errors which the registered manager told us was a 'glitch' in the system and were not real errors. There was no action plan in place to establish if people's care had been compromised during this time. Staff said the new systems were complicated and were not always effective in allowing them to complete a detailed, timely and accurate report of the care delivered.

The provider did not have effective quality monitoring systems in place to identify when changes to people's care occurred. For example, care staff had identified and recorded deterioration in a person's mental health, which placed them at immediate risk of harm. Procedures had not been followed to protect this person resulting in them remaining unsafe in the home. Quality monitoring systems had failed to pick up when this issue had not been appropriately escalated; therefore the person had remained unsafe in the home.

Reports had been completed for some incidents that had occurred in the home. However, these did not in all cases reflect the incidents found during the inspection. For example, the number of medicines error reported as part of an incident report did not reflect the numbers found when we looked at medicines records. Systems did not allow for a clear overview of incidents or a process for considering lessons learned or future practice in relation to incidents and complaints.

The provider had notified CQC of some incidents in the home. However, the absence of a clear overview of incidents meant we were unable to ascertain if all incidents had been escalated and reported as required.

Although audits had been undertaken in relation to the environment and people's care, they had not been effective in picking up the concerns found during the inspection.

The provider did not have sufficient systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the systems for documenting people's personal information and care arrangements were inconsistent and did not ensure staff had access to information they needed to provide safe, effective and responsive care. We found gaps in records, which meant we were unable to ascertain if people's needs were appropriately met. For example, the records for one person with diet controlled diabetes were not consistently recorded. There was one full day when no record of any meals was recorded. Some people had

been assessed as requiring monitoring of fluids due to risks associated with skin conditions. We found inconsistency in the way fluid intake was recorded and gaps in monitoring forms. This meant we were unable to ascertain if this person's nutritional and hydration needs were being met.

Other agencies we spoke to said they could not always find the information they needed to make an assessment of a person's progress or needs for future planning.

People's personal and confidential information was not always protected and stored securely. We saw a number of files in unlocked cabinets or left on the desks in communal parts of the home. A filing cabinet in a hallway with people's personal information was unlocked throughout the inspection. One of the desks where staff completed records was situated at the end of a communal corridor. IT equipment was also located in this area and was not securely stored. We saw external professionals were able to access confidential files without supervision or any agreed process to ensure confidentiality.

Records were not always completed accurately or in sufficient detail to reflect the care being delivered. Records were not well maintained or stored appropriately to ensure people's personal information was protected. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not demonstrate learning or improvement as a result of concerns or complaints raised with them. We looked at recent complaints and correspondence from people who had remained unsatisfied with the providers to their concerns raised. It was not evident that the provider had listened to the views of the complainant or used the concerns raised to consider improvements to the service and people's care.

We received mixed feedback about the management and leadership of the service. Positive comments included, "They really supported me to pursue my nursing qualification" and "There is an open door policy for supervision and support". However, we received mixed feedback about the culture of the service. Staff said they did not always feel they were valued and felt the leadership could at times be "negative and unprofessional". Staff said this had at times resulted in low morale and reluctance by staff to raise issues or share ideas. Staff meetings took place but some staff said more recently these had been used by management as a time to tell them what to do rather than a forum for shared learning and reflection on practice.

The registered manager was open and supportive throughout the inspection. They said recruiting and maintaining qualified nursing staff had been a problem, and the agreement by the provider to support people for a short period of rehabilitation following discharge from hospital also added some additional pressures for the staff team. The registered manager had made efforts to address these issues by recruiting nursing assistants to support qualified nursing staff and attending regular multi-agency meetings to discuss issues relating to people discharged from hospital for a short stay.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure people's privacy and dignity was respected and protected. This is a breach of Regulation 10 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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not sufficient to prevent and control the spread of infection. This is a breach of Regulation 12 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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not effectively record, handle and respond to complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.