

Bupa Care Homes (GL) Limited

# Westcombe Park Nursing 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

This inspection took place on 11 and 12 November 2015 and was unannounced. At the last comprehensive inspection on 7, 8 and 11 May 2015 we had found serious breaches of regulations in respect of safe care and treatment in relation to risk and safe management of medicines. There were additional breaches in respect of

arrangements for consent, quality assurance and treating people with respect and dignity. We also made a recommendation for the provider to review their staffing levels.

We had served a Warning Notice in relation to the more serious breaches found and followed up on these breaches at a focused inspection on 11 August 2015. Some concerns about safe care had been addressed but

# Summary of findings

there were further concerns in respect of the safe management of medicines. On 24 August 2015 we imposed urgent conditions on the provider in respect of arrangements for people who self-medicate. We set a review date for the conditions of within four months of the date the notice was served.

We carried out a comprehensive inspection on November 11 and 12 November 2015 to check if the remaining breaches from our inspection of 7, 8, and 11 May had been addressed and to provide a fresh rating for the service.

Westcombe Park Nursing Home accommodates up to 51 people who have elderly, nursing or residential care needs. There was no registered manager in place as they had left the service on 8 October 2015. An interim manager had been appointed and started at the service on 12 October 2015. This manager had previous experience of being a registered manager. 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.

Since the last inspection 14 safeguarding investigations had been raised in respect of people's care. Two had been substantiated at the time of the inspection. Eleven of these alerts arose following concerns raised by the GP after visits to the service on 15 September 2015 and 22 October 2015. The provider had placed a voluntary embargo on new admissions following a meeting with the local authority on 16 October 2015.

At this inspection we found further breaches of regulations in respect of people's safe care and treatment. There was a lack of communication about people's clinical care needs. Risks to people in relation to their health and care needs were not always identified or assessed or action taken to manage the risks. Records in relation to people's care were not accurately maintained. Systems to manage and monitor the quality of the service were not operated effectively. There were not always adequate numbers of staff deployed at the service. Arrangements to monitor the competency of nurses were

not robust. There were inadequate arrangements for staff supervision and support. CQC is currently considering the most appropriate regulatory response to the concerns found and will report on this at a later date.

People told us that they felt safe and well cared for. They were positive about their relationships with permanent day staff and we observed warm and friendly interactions between staff and people using the service. However people told us they found night staff less caring. We found that the arrangements for the management of medicines had improved significantly. Staff were knowledgeable about the signs of possible abuse and what to do if they had concerns. People told us they were treated with respect and dignity by day staff and we observed some improvements had been made although there was still room for further improvement in the care provided. People had an assessed plan of care and told us they were involved in planning and reviewing their care and that their independence was encouraged. Some staff demonstrated awareness and an understanding of the people they supported and people's individual religious and cultural needs were recognised and addressed.

Arrangements for the administration, recording and management of medicines had improved. The conditions imposed following the previous inspection had been consistently met. We have therefore reviewed our decision in respect of the conditions we imposed in August 2015, for the arrangements for people who self administer, and these have been removed from the provider's registration.

People were provided with enough to eat and drink but there were a range of comments about the quality of the food. People were asked for their consent before care was provided. Arrangements to work within the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were in place. Staff mandatory training was up to date. There was a complaints procedure in place and the provider sought feedback on the service. Residents and relatives meetings were held to communicate changes and listen to feedback, there was a suggestions box and an annual survey was carried out.

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

# Summary of findings

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 consider the process of preventing the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe. Safe care and treatment was not always provided as risks to people were not always identified or assessed. There were not always sufficient numbers of staff deployed. Not all staff had been prepared to respond appropriately in the event of fire and they had not been involved in a fire drill.

Staff were aware of the potential signs of abuse to look out for and knew the action to take if they had any concerns. Equipment including fire-fighting equipment was routinely checked and serviced. Staff had received first aid training and knew how to respond in a medical emergency. Medicines were administered safely.

**Inadequate**



### Is the service effective?

The service was not consistently effective. Staff received regular training across areas the provider considered mandatory. However arrangements to ensure that nurses had required training to meet people's treatment needs were not robust and competency assessments had not always been completed. Staff had not received regular supervision and support.

People were asked for their consent before they received care and arrangements for seeking authorisation for DoLS when needed were in place. People told us there was enough to eat and drink but there were a range of comments about the quality of the food provided.

Healthcare professionals found staff caring but that they did not always know people's health needs well and records were difficult to follow to ensure treatment was being delivered as needed.

**Requires improvement**



### Is the service caring?

The service was not consistently caring.

People said that day staff were kind and caring. We overheard some staff refer to people by room number rather than by name. They told us they were consulted about their care and we saw this evidenced in people's care plans. We observed some thoughtful and considerate interactions between staff and people and the atmosphere at times was welcoming and warm.

Relatives told us they were free to visit at any time and were made welcome but could struggle to gain access at evenings and weekends as the reception area was not staffed at these times.

People and their relatives told us that day staff treated them with dignity and respect and we observed this to be the case. People did not always experience caring treatment from night staff.

**Requires improvement**



# Summary of findings

## Is the service responsive?

The service was not consistently responsive.

People told us that their care was personalised and met their needs. However people's care records were not always accurately maintained. People spoke highly of the activities organiser but their individual needs for stimulation and interaction were not always consistently met.

People were aware of how to make a complaint and the provider's policy and procedure was displayed in communal areas to make information accessible.

**Requires improvement**



## Is the service well-led?

The service was not well- led. The previous registered manager and deputy had left and an interim manager had been recently appointed to the post. There had been an absence of sufficient senior staff to drive and maintain improvements.

Systems to monitor risks and improve the quality of the service were not operated effectively. Meetings to ensure good communication in respect of people's clinical care were not taking place. Audits and checks were not always completed and where they were they did not identify the issues found at our inspection.

People's views about the service were sought and feedback we received about the running of the service was positive.

**Inadequate**



# Westcombe Park Nursing 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 11 and 12 November 2015 and was unannounced. On the first day the inspection team consisted of two inspectors, a specialist advisor in nursing and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there were three inspectors, a specialist advisor in nursing and a pharmacy inspector.

Before the inspection we looked at the information we held about the service including information from any notifications they had sent us and updates on their action plan. A notification is information about important events

that the provider is required to send us by law. We also asked the local authority commissioning the service and the safeguarding team for their views of the service and we spoke with the visiting GP for the service.

During the inspection we spoke with 25 people who used the service and six relatives. We spoke with three senior nurses, three nurses and two night nurses, nine care workers including three night staff, the maintenance person, the interim chef, the activities coordinator, and reception staff. We also spoke with the interim manager and the area manager on both days of the inspection as well as four visiting health and social care professionals. We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at ten people's care records, seven staff recruitment and training records and records related to the management of the service such as, minutes of meetings, records of audits and equipment and premises checks. After the inspection we spoke with two health care professionals to gather their views about the service.

# Is the service safe?

## Our findings

People and their relatives told us they felt safe and well cared for at the home. One person told us “I’m quite safe. The thought of danger doesn’t occur!” Relatives were also of the view that their family members were safely cared for. A relative said “they are safe and well cared for.” However our findings did not always support people’s views.

Prior to the inspection concerns had been raised in October 2015 about the home’s ability to meet people’s clinical care needs. Seven safeguarding alerts had been raised on 16 October 2015, following a GP visit on 15 September 2015 and were being investigated by the local authority at the time of the inspection. Three other safeguarding investigations had been raised in relation to the GP round of 22 October 2015; these were also being investigated. A previous safeguarding alert raised by a relative had been substantiated as neglect in relation to a fall from bed. A safeguarding alert in relation to medicines raised by CQC following the last inspection in August 2015 had also been substantiated. We met with the provider who told us they had taken action in response to all the concerns raised.

At this inspection we found that risks to people in relation to their clinical care were not always identified or actions taken to reduce these risks. For example, one person had been identified by the Speech and Language Therapist (SALT) as being at risk of choking. We found that the SALT team had made recommendations about this risk but this information was not located prominently in the person’s care plan. Staff were not updated with the recommendations and kitchen staff were not aware of the kind of diet that the person required to meet their dietary needs safely. We saw that there were food items within reach of the person which could place them at risk of choking and this had not been identified by staff. Another person had not received antibiotics for a urinary tract infection as prescribed by the GP.

Risks in relation to people with specialist feeding regimes were not always identified or monitored. In one person’s care notes a staff member had recorded a need for a referral to the GP and SALT on 01 November 2015, due to a possible risk of choking. We could not find any evidence to demonstrate that the necessary action had been taken. A senior nurse we spoke with was not aware of this until we pointed it out. For another person on a feeding regime

there was no evidence to show that the care delivery was carried out weekly in line with the care plan or that the required equipment had been monitored and cleaned effectively to avoid the risk of infection.

Risks in relation to malnutrition and hydration were not always monitored accurately. Staff on two of the floors of the home were not clear about whether people they supported had a food and fluid chart in place to monitor risk. There were no protocols to guide staff on their use. We saw a fluid chart for one person whose daily fluid intake had not been totalled up or checked by a nurse at the end of the day to establish if any action needed to be taken. Other people whose needs included careful monitoring of food and fluid intake did not have charts in place to ensure this was monitored accurately.

Risk in relation to weight loss was not always identified. One person had lost significant weight since they were last weighed in October 2015 but this had not been identified, nor a new risk assessment completed to check if their level of risk had changed.

One person’s care plan stated they were unable to use a call bell to summon for help. The care plan stated, “Care staff complete regular checks.” However care workers told us these checks were not recorded. Therefore we could not monitor if care was being delivered in line with the person’s assessed needs.

Arrangements to manage risks in emergencies were in place; however they were not sufficiently robust. Fire safety training was provided and we saw two fire drills for day staff carried out in 2015. Two members of night staff, who had worked at the service for 6 months and two years respectively, told us they had not taken part in a fire drill and were unclear what to do in the event of a fire. We verified from records, there had been one fire drill for night staff in 2015, and those staff members were not present. Therefore in the event of an emergency people could be at risk of unsafe care because not all staff knew of the provider’s fire evacuation procedures or taken part in a fire drill.

These issues were breaches of Regulation 12 of the Health And Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate records in respect of people’s care were not always maintained. Records to monitor and reduce risks were not always completed. For example repositioning



## Is the service safe?

charts were not always completed to show that people were repositioned in line with their identified care needs. For three people using the service we found their wound care records were not completed adequately for each separate wound to enable staff and healthcare professionals to track their progress or deterioration. Catheter care records were not always completed to track the frequency of changes. Therefore people were at risk of receiving unsafe care because appropriate records were not maintained.

This was a breach of Regulation 17 of the Health And Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risks to people were identified and measures in to reduce them. Maintenance checks and servicing was carried out routinely on all equipment and the premises. These included legionella checks on the water, fire equipment, hoists, gas and electricity and call bells.

People told us there were not always enough staff to support them. One person told us “The staff are lovely but they are all so busy and just don’t have time to help.” A relative said staff sometimes told her they had to leave her family member in bed longer than they wanted as they were short staffed, they told us “I have thought that breakfast at 11a.m is too late really.” We observed that people sitting in the small lounge on the first floor were unoccupied and without a staff presence for periods throughout the day.

The area manager told us that the day time staffing levels at the service had been reviewed as recommended from the inspection on 7, 8, and 11 May 2015 and each floor had an increase of one care worker during the day since the last inspection. They told us call bell response times were also monitored on a daily basis. We checked the call bell response times at the inspection and staff responded promptly. However some people told us staff came quickly to answer the call bell but were not always able to assist them straight away as they were dealing with someone else. One person told us “They moan if you do it too much, the buzzer. One night nurse threatened to take it away and she did do.”

We saw from staff rosters that there were not always enough staff on duty For example on 4 November there were only two nurses on the roster for the whole service and one of these was an agency nurse. We saw an incident report dated 4 October 2015 which stated that the agency

nurse did not arrive for their shift and so there was only one nurse for the two floors. The incident report stated “possible error in documentation left unfinished due to insufficient staff levels.” On 26 October 2015 there were only six care workers on duty instead of the assessed need of eight. There were days when the roster total was inaccurate. For example on the 30 October 2015 there were five care workers on the roster although the total number shown on the roster was eight in the morning and seven in the afternoon.

There were not enough staff deployed at night. We visited the service at 6. 45 am on 12 November 2015 and found the correct levels of staff present. There were two nurses and three care workers to meet people’s needs. There was a single care worker on the ground floor, although several people on this floor had nursing needs and required two staff to reposition or support them mobilise. On another floor there was a single care worker as the nurse had gone to administer medicines elsewhere in the building. During this time, there was a person in the lounge that needed reassurance and was calling out, another person who was requesting their pain relief and two call bells ringing. The care worker was unable to meet everyone’s needs in a timely way.

Minutes of a relatives meeting held on 22 October 2015 advised relatives that additional nurses would be on duty to ensure “the senior nurse could oversee the clinical running of the home”. However checks of the staff roster rota showed that the senior nurse was not supernumerary on any day for the weeks of 30 October 2015 and 6 November 2015 but working as one of the three identified nurses needed for each day. This meant they were not available to oversee the clinical running of the home and ensure people’s treatment needs were met. There were therefore insufficient numbers of staff deployed at all times to meet people’s needs

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

After the last inspection of 11 August 2015 we imposed an urgent condition on the provider to send us weekly audits in respect of self- medication arrangements. Our monitoring checks showed this condition had been observed and complied with. At this inspection we found arrangements for people who self-medicate were



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monitored regularly and were more robust; although there was no recorded date for a full review of the arrangements. This was discussed with the interim manager who agreed one would be arranged.

At this inspection we found there had been a recent change of pharmacy supplier. There was a new medicines administration record (MAR) was in place and the medicines administration process had significantly improved since the last inspection.

People told us they received their medicines as prescribed and there were no problems with the support they received. We saw medicines were stored safely and disposed of properly when required. There were policies that followed current and relevant professional guidance about the management and review of medicines.

However at our inspection, we noted the length of time taken to administer medicines on the top and middle floors took almost two hours. Nurses told us this was not unusual. We discussed this with the manager. We were told that

nurses prioritised people who were at most risk of not receiving their medicines on time. The area manager and interim manager told us that this issue had been identified in an audit and they were looking at a senior carer role being introduced to reduce these concerns.

Following this inspection, we reviewed the conditions imposed on the provider's registration in respect of arrangements medicines for people who self administer. In light of the evidence of improvements in this area we have removed the conditions we had imposed following the previous inspection in August 2015.

People told us they felt safe from abuse and discrimination. One person told us "Of course I am safe." Another person said "It's perfectly safe. I have nothing to worry about." Staff were aware of the possible signs of abuse and what to do if they had any concerns. The interim manager knew how to raise safeguarding alerts if required. Staff understood what was meant by whistleblowing and where they could go to raise concerns.

# Is the service effective?

## Our findings

People told us they thought the staff had enough skills and knowledge to carry out their roles. One person commented “The staff know what to do, there is a lot to do and they know how to do it.” Another person told us “The staff are helpful. It’s their job to be and they are good at it!”

However, while training was provided and refreshed, we found some competency training for qualified nurses was not in place. For example we asked for evidence of training for catheter care for nurses and the interim manager was unable to provide this. Following the inspection we were sent a training certificate for one nurse dated 2006 but no training certificate for a second nurse who had documented they had carried out catheter care. There was no evidence of any competency assessments carried out in respect of this aspect of nursing care or that guidance in relation to this was followed. Guidance from the Royal College of Nurses on catheter care states that in all care settings nurses should have observed clinical practice and training refreshed every five years.

At the last inspection we had found that regular staff supervision did not always take place and supervision arrangements required some improvement. At this inspection we found this remained the case and that staff did not receive regular formal supervision sessions to support them in their roles. The area manager acknowledged that this was an area that needed improvement so that staff received sufficient support to carry out their roles.

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

Staff had received training in the areas the provider considered mandatory. This included areas such as Safeguarding Vulnerable Adults; Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS); Dementia Awareness; Moving and Handling People; First Aid and Fire Safety. There were up to date medicine competency assessments for all registered nurses. The staff training matrix indicated that mandatory training was up to date; any gaps in training were due to staff sick leave or maternity leave. New

staff received an induction this included a period of shadowing and completion of mandatory training. Completed induction check lists were placed on staff records to verify their training.

At the last comprehensive inspection on 7, 8, and 11 May 2015 we had found a breach of regulation as people’s rights in respect of decision making were not always upheld and there was evidence that the provider had not always acted in line with the requirements of the Mental Capacity Act (2005) Code of Practice and Deprivation of Liberty safeguards. The provider sent us an action plan and told us they would comply with the regulation by 31 July 2015.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us they were asked for their consent before care was provided and we observed this to be the case during the inspection. Staff had received training on MCA and been provided with a memo guide to remind them of the principles behind the law and how it affected their work. We found there were new documents to record people’s choices and capacity to make specific decisions. There were separate capacity assessments for specific decisions in place, for example decisions about self-medication. Where people may lack the capacity to make some decisions there was evidence that relatives and or health professionals were involved in decision making in their best interests. The provider had completed appropriate assessments and applications for DoLS, which were going through the authorisation process with the local authority, as the supervisory body.

## Is the service effective?

People told us they had enough to eat and drink and that they had a choice but we received mixed feedback about the quality of the food provided and some improvements were needed. We had some positive comments about the food from five people and some relatives, one person said; "It is marvellous!" Another person told us, "The food is very good. You know what you are eating." A relative remarked "The food is very good here. A menu, an excellent choice, more than enough and they are most accommodating in the kitchen, going out of their way." Three other people were less sure: one person commented "I wouldn't say it's perfect. It's not always what I like." Another person noted, "The food is quite all right as far as it goes but could be cooked more." There were five people who expressed strong adverse feelings about the food: three of these people finding the food cold when it reached them. One person said, "The vegetables are awful, the cheese and biscuits are tiny and the corned beef hash has no corned beef!" A second person remarked, "The food is not good and always cold. The meat is hard. I am not eating it much." A third person told us "You have a meeting (about the food) but it is a waste of time as nothing happens." People chose where they ate their meals and the majority of people ate in their rooms. Cultural dietary needs were recorded in people's care plans and the kitchen staff were aware of people's needs in this respect. We saw people were offered a choice of drinks throughout the day to keep them hydrated.

We discussed the feedback with the interim manager and area manager. They told us there had been difficulties with the previous chef and an interim chef was now in post. They had re-established a monthly food committee to try and improve the meals and were addressing the food temperature issues.

People said they had access to a range of health care professionals when required which included the GP, dentist and optician. One relative commented, "If I say that I think she has a chest infection, because I know her and I can hear it, they get the doctor in." As a result of the concerns raised by the GP following recent visits the provider had advised that a dedicated staff member would accompany the GP on their visits to people to ensure good communication about people's needs. We found a new system had been introduced to record the GP's advice and ensure actions recommended were followed up. Health professionals we spoke with during and after the inspection told us that staff were caring but busy and did not always know people well. They said records at the home could be difficult to follow and it was sometimes a struggle to find staff. The GP advised that the communication had improved in recent weeks. Referrals were made appropriately where identified changes were observed.

# Is the service caring?

## Our findings

At the last inspection in May 2015 we found a breach of regulations as people were not always treated with dignity and respect. Staff had been observed to enter people's rooms without knocking. We made a requirement action of the provider to address these concerns. The service had sent us an action plan to address the issues identified. They told us they would become compliant with the regulation by 31 July 2015.

At this inspection people told us they were treated with respect and dignity by staff and our observations throughout both days found this to be the case. One person said "they are very good and I am looked after very well." Another person commented "They have been very kind to me. I was shy at first but they were very good." A relative told us they were "very happy with their family member's care here. It is the best: they have made friends and this is the happiest that they have been for ages." Staff knocked on people's doors before they entered and spoke politely with people. People told us their dignity and privacy were maintained during personal care; that staff knocked and waited for a response before entering their rooms, covered them appropriately when they provided personal care. Staff generally understood the importance of dignity and respect and told us doors and curtains were always closed prior to providing people with personal care and our observations confirmed this.

We found there were some areas for improvement in the way some staff interacted with people using the service. We overheard a staff member refer to room numbers rather than to people by name and on one occasion and at another we observed a care worker turn on a person's light without first checking if they were happy for this to be done. We received a range of comments from people and two relatives about the way night staff provided care and support. One person said "Some of the staff at night are not nice and one is very bad. They don't help at all." Another told us, "The only carer I don't like is a night one. She is very rude to me." A relative stated their family member "has had problems with a night staff .... The day staff, however, are excellent." We discussed these concerns with the manager who told us they had not received any specific feedback or

complaints about night staff. They agreed that while there had been improvements to the culture at the service in terms of how people were respected the feedback suggested there was still room for improvements.

Relatives told us there were no restrictions on visiting and that staff were warm and welcoming. However they told us they sometimes had difficulty in gaining access to the building at weekends or late in the evening as staff were busy when they arrived and there were no reception staff on duty. Staff confirmed that this was a problem that had been going on for some time. One relative told us they "felt welcome at the Home, apart from on Saturdays when no one lets you in. I have to keep buzzing and buzzing out in the cold." We informed the manager and area manager of this problem.

We observed a morning handover which was conducted in each person's room with them, a member of night staff and the new day staff on duty. Staff told us this was also the pattern at night. We observed that staff knocked before entering and we overheard meaningful and pleasant conversation taking place in some rooms with people. For example staff sang happy birthday to someone who appeared to appreciate this. However in other rooms we overheard the handover did not involve people using the service and they were talked about rather than being able to join in. There was no evidence that this meeting in people's rooms had been discussed with people to confirm they were happy with this daily arrival of staff in their room at this time in the morning.

We observed many positive and meaningful conversations between care workers and people using the service. They provided care sensitively and cheerfully throughout the day, for example, we saw that they reassured a person when they were upset. Staff interactions with people were patient and caring. We saw a member of staff being very persuasive with one person who had not eaten. They spoke kindly and with great patience and managed to encourage the person to eat some lunch. Later the care worker demonstrated a depth of knowledge about that person to us.

Staff interacted with appropriate humour on occasions and some staff clearly knew people well and were able to describe their preferred routine or interests. One person using the service told us "I get on with them all and we have a good laugh. It is good for us to laugh. They are all

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lovely.” Another person said the staff are all “good and definitely helpful.” We saw two care workers outside shared their break with two people using the service and engaged in an enjoyable conversation.

However, staff did not always know people’s needs and routines, when they were new to working at the service. Agency staff did not know people well and an agency nurse at the inspection was unable to tell us how many people they were supporting on the floor they were working on, although they were three hours into their shift. The manager told us they tried to ask for the same agency staff as much as possible so that they would become familiar with people’s needs. Other care staff were new to the service or worked usually on a different floor and so were not always familiar with people’s needs or routines when we asked.

People and their relatives told us they were involved in their care and consulted about any changes. They said they had been involved in reviews of their care and support

needs and that staff listened to their views. They felt their independence was encouraged wherever possible. Notice boards throughout the service displayed the activities time table, information on how to make a complaint and feedback about actions taken in response to any issues were displayed to ensure information was easily accessible to people. The manager told us that people had requested to restart a food committee at a recent residents meeting and the first meeting was held during the inspection. Dates had been arranged for monthly meetings subsequently and people’s involvement was encouraged.

People’s diverse needs, independence and rights were supported and respected. Where people had identified communication difficulties they had access to equipment which enabled them to communicate more effectively for example with picture cards or specialist equipment. People told us their spiritual and cultural needs were identified and they were supported with visits by representatives of a variety of faiths.

# Is the service responsive?

## Our findings

At the last comprehensive inspection on 7, 8 and 11 May 2015 we had found breaches of regulations as people's assessed plans of care were not always up to date and did not reflect their current needs. A new care recording system was in the process of being implemented. The provider sent us an action plan which said they would meet the regulation by 31 August 2015.

At this inspection we found accurate records regarding people's care and treatment were not always maintained. The provider had completed the change to the new care documentation and people's records had all been transferred to the new system. However some documentation related to people's care needs such as health professionals' reports or outcomes from hospital appointments were missing from the new records. This meant it was not always possible for staff to verify that the care being given followed health professionals' recommendations. When we requested to see these records they could not be located in the archive. Records related to people's wound care, percutaneous endoscopic gastrostomy tube and catheter care were difficult to follow and not always recorded in the same place in the care file. There were charts to monitor people's care but the area manager told us staff may record this care in the daily notes and not on the available charts. When we requested these notes they were not always located in the archive. This made it difficult to monitor the care provided and ensure it was meeting people's needs.

The manager showed us a written handover record that they said would be completed for each handover to assist all staff but particularly agency staff to understand people's needs and any changes. However the handover sheet on two floors was a week old and we could see it did not include recent changes such as a person using the service being admitted to hospital. One agency nurse who said they had not received a written handover sheet for that week and we saw they used a handover record dated 29 October 2015 which they told us they had found in the office. Accurate records regarding people's care were not therefore available and there was a risk agency staff may not be aware of recent changes to people's care.

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

People told us they had an assessed plan of care to meet their needs and there was evidence that people and their relatives, when relevant, were involved in the review of care plans and notified of any changes. People's care plans were personalised and there was guidance for staff on how to meet these needs. The care plans were up to date and had been reviewed although we found three records had not always been reviewed monthly in line with the provider's requirements.

Arrangements to meet people's need for stimulation and reduce isolation required some improvement and this was recognised by the interim manager. Everyone was complimentary about the activities organiser and we observed them to engage people positively and enthusiastically. One person said the activities organiser "is wonderful, she makes it all happen and looks after us well." Another person commented "the activities lady is marvellous. She takes an interest individually." People told us there were things to do and they liked the activities on offer but that they would also like to go out more and would like some things to do at weekends. One person said "It is very flat at weekends and there is not enough to do." The activities coordinator worked across the service Monday to Friday and had involved work experience students to assist them. There was a weekly activities planner and people knew what activities were on offer that day. Not everyone was able or chose to go to the main lounge for activities and some people sat in the lounges on each floor or in their rooms. The activities organiser visited the other lounges for short periods of time to engage with people and told us they visited those people in their rooms who wanted to take part in individual activities. However we observed that it was difficult for the activities organiser to cover all these different areas effectively across the home to ensure everyone's needs for stimulation were met.

At this inspection we found the handling of complaints needed some improvement. Some complaints were handled appropriately but two other complaints we were aware of were not logged in the complaint record. People and their relatives told us they were aware of how to register a complaint and the complaints policy was visible on each floor of the service. We looked at the complaints log and found that complaints were handled in line with the complaints procedure. We saw two compliments from relatives about the care provided which had been received since the last inspection.



# Is the service well-led?

## Our findings

At the last inspection of 7, 8 and 11 May 2015 we had found a breach of regulations as the system to monitor the quality of the service was not always operated effectively to identify issues, or, where these concerns were identified they were not promptly acted upon. At this inspection we found this remained the case.

The registered manager had been on leave in September 2015 and then resigned from the service with immediate effect on 8 October 2015. The deputy manager had been on sick leave and then resigned. A number of nurses and care workers had also left the home since the last comprehensive inspection and the service had been running with a high level of agency nurse use.

An interim manager had started on 12 October 2015. We were told they were supported by the area manager with regular visits and there was support from the provider's quality team. However, checks of the records for the running of the service showed processes for the communication, management and oversight of people's care appeared to have been interrupted since the end of August 2015 and regular meetings were not always held.

Systems to monitor and reduce risks were not being operated effectively. For example we had been told in the service action plan that the daily "Take 10 meeting" was being used to discuss call bell response times. However there was no evidence of a Take 10 meeting since 19 October 2015. Therefore risks in relation to call bell response times were not being discussed in line with the improvement plan.

People were not protected from the risk of unsuitable staff as robust systems were not operated in respect of the employment of agency staff and risks were not sufficiently monitored. We found there was no available record of a check for an agency nurse who was on duty during the inspection. They told us they had worked at the service several times before. A record of their identity and training was eventually found in the previous registered manager's emails. The area manager agreed there was not a robust system as this information had not been accessible for current staff to check when the nurse started work at the service. The area manager said the folder containing

agency workers would be kept accessible at all times in future and the member of staff receiving the agency worker would check their credentials before they were allowed onto the floor.

However, despite the concerns raised by the GP in relation to people's clinical care regular weekly review meetings had not been held. We found minutes for two meetings held on 1 September 2015 on one floor and 5 November 2015 for another floor, but no further minutes of meetings were shown to us when we asked. We also found that the clinical walk around the manager undertook to check on standards of care delivery did not include action plans, so that when issues were identified we could not see that action had been taken to ensure safe care delivery.

Issues that required investigation were not followed up in a timely way. We found concerns about call bell response times which had not been fully investigated. The previous registered manager had begun to investigate one complaint from 1 October 2015 but this had not been completed and not followed through subsequently. We found a further concern noted in the minutes of a Take 10 meeting on 19 October 2015 that recorded a person using the service had described that they needed to break a glass to attract staff attention as their call bell was not answered in a timely manner. This had not been investigated by the interim manager or area manager. There was also no investigation process started in relation to an investigation in relation to staff involved in the communication problems that gave rise to the seven safeguarding alerts raised on 16 October 2015. Appropriate action was not being taken to protect people from further risks or to improve the quality of the service.

There was no programme for unannounced night spot checks to monitor care delivery at night. This was despite the fact that a concern about sufficient staff at night was voiced at the residents meeting on 29 October 2015. One night support visit had been carried out on 2 November 2015 by a manager of another service. However night staff told us this visit was planned and we saw from the record the visit was to provide both quality assurance and supervision, coaching and mentoring to all night staff.

Accidents and incident records from October 2015 had not been analysed to identify that three falls had occurred on the same day. When we asked the interim manager to review this they advised that there had been the right



## Is the service well-led?

number of staff on duty. However our check of the rota for that day confirmed the service had been a nurse short on the floor where two of the accidents occurred. This had not been identified or considered in the analysis.

Systems to monitor the quality of the service were not operated effectively to identify any concerns. Audits to monitor the quality of the service were not completed as required. We asked about the audits that according to the provider schedule would have been completed in August, September and October 2015. These included health and safety, care infection control, medication, GP's visits and nutrition. The area manager told us the medication and GP audit had been completed but it had not been possible to complete all the other audits due to the problems experienced with the changes in manager. We were told spot audits were being completed on care records but we were unable to locate any and none were available to be sent to us following the inspection. We were told the quality manager was on leave and they were unable to supply them. Monthly Provider review visits carried out by the area manager failed to identify the issues found at our inspection.

These issues were all breaches of Regulation 17 of the Health And Social Care Act 2008. (Regulated Activities) Regulations 2014.

Regular medicines audits were carried out to ensure medicines were managed safely. Staff who administered medicines were aware of the provider's policies around reporting of medicines errors. The interim manager advised that any incident was investigated, a root-cause analysis done and learning from mistakes disseminated via monthly meetings. The system had recently been established and therefore monthly meetings had yet to be held, but daily checks and monthly audits of medicines had been regularly carried out to monitor the quality of care provided.

Feedback from people and their relatives about the running of the service was mainly positive. Four people told us they had not met the new manager as yet but they were aware there had been changes. One relative told us, "There's been a recent change of manager, but I haven't seen (them) yet. They are only temporary I think. They don't tell you much. I've heard from sources that there have been complaints but on the whole, it is quite nice here." Another person said, "There's an interim manager so far. (The last one) was a nice lady and the deputy too. But they've gone now." A third person described it as "a very good home with good food and entertainment." A relative told us it was "a first class home."

The service asked for feedback from people and relatives through an annual survey. We were told the results for 2015 were not yet available. There was also a comments and suggestions box in the entrance hall. Relatives were aware that meetings were organised for them if they wanted to attend.

Staff told us that the atmosphere at the service had been difficult following the last inspection and the staff team had been divided. Some staff had felt unfairly personally blamed for failings in the service. Other staff told us they felt let down by the poor attitude of some agency staff, who, they felt did not have the commitment to the home that the permanent staff had. They told us the area manager had been instrumental in helping them feel more positive and in moving forward as a team together. We observed that most care workers and nurses were positive and wanted to improve the quality of the care provided. The area manager told us a new manager and deputy had been appointed to the service to begin work there in January 2016.

This section is primarily information for the provider

## Enforcement actions

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

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**Safe care and treatment was not always provided as risks to people were not always identified assessed or plans put in place to reduce risk.**

Regulation 12 (1) (2) (a) (b)

#### **The enforcement action we took:**

CQC is currently considering the most appropriate regulatory response to the concerns found and will report on this at a later date.

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**Systems to assess, monitor and improve the quality and safety of the service and to identify and reduce risk to people were not effectively operated.**

Regulation 17(1) (2) (a) (b) (c)(f)

#### **The enforcement action we took:**

CQC is currently considering the most appropriate regulatory response to the concerns found and will report on this at a later date.

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed and there were inadequate arrangements for staff supervision**

Regulation 18(1) (2) (a)

#### **The enforcement action we took:**

CQC is currently considering the most appropriate regulatory response to the concerns found and will report on this at a later date.