St Dominic's Limited

St Dominic's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected St Dominic's Nursing Home on the 9,12 and 14 September 2016. The inspection was unannounced.

St Dominic's Nursing Home is registered to provide care to people with nursing needs, such as Parkinson's, diabetes, and heart failure, many of whom were also living with dementia. The home was divided into six units over three floors, Fern, Crocus, Dahlia, Aster and Bluebell and Elderflower. Fern unit was on the lower ground floor and was home to people living with complex dementia needs. The home can provide care and support for up to 91 people. There were 73 people living at the home on the days of our inspection.

There was a registered manager in post. A registered manager had recently been transferred from another home in the organisation and was in their third week at St Dominic's Nursing Home. 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 and associated regulations about how the service is run.

The comprehensive inspection in November 2014 rated this service as inadequate. At this time we took enforcement action. Breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. We found significant risks due to people not receiving appropriate person centred care. Where people's health needs had changed considerably, care plans had not been updated. Staff did not have the most up to date information about people's health. This meant there was a risk that people's health could deteriorate and go unnoticed. Risk assessments did not reflect people's changing needs in respect of wounds and pressure damage. Accidents and incidents had not been recorded appropriately and steps had not been taken by the staff to minimise the risk of similar events happening in the future. People had not been protected against unsafe treatment by the quality assurance systems. We also found that training had not been delivered where identified and administrative processes to support training, staff supervision and appraisal were inaccurate and incomplete. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by January 2015.
During our inspection in February and March 2015, we looked to see if improvements had been made. The inspection found that improvements had been made and breaches in regulation had been met.

Due to a high number of concerns raised about the safety of people, the meal service and staffing levels we brought the scheduled inspection forward, so we could ensure that people were safe.

This inspection found that people's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as diabetes, kidney problems, and wounds were not up to date and did not have sufficient guidance in place for staff to deliver safe treatment. The lack of suitably qualified and experienced staff impacted on the care delivery and staff were under pressure to deliver care in a timely fashion. Shortcuts in care delivery were identified particularly in respect of personal care. We also

found the provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not always following the principles of the MCA. There were restrictions imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice. There was confusion over whether deprivation of liberty safeguards (DoLS) were in place for people. The management list of DoLS was not up to date or accurate.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes and dislikes. Information in respect of people's lifestyle choices was not readily available for staff. The lack of meaningful activities impacted negatively on people's well-being.

People, staff and visitors were not always complimentary about the meal service at St Dominic's Nursing Home. The dining experience was not a social and enjoyable experience for people on all units. People were not always supported to eat and drink enough to meet their needs.

Quality assurance systems were in place but had not identified the shortfalls in care delivery and record keeping. We could not be assured that accidents and incidents were consistently investigated with a robust action plan to prevent a re-occurrence.

People's medicines were not always stored safely and in line with legal requirements. There were gaps found in the recording of medicines of topical creams, dietary supplements and 'as required' PRN medication. Shortfalls identified by the pharmacy provider were still outstanding and had not been actioned by staff.

People and visitors we spoke with were complimentary about the caring nature of some of the staff. However the constant changes to staff, use of agency staff and staff leaving had impacted on how the home was run. Many people were supported with little verbal interaction, and many spent time isolated in their rooms.

Staff told us they thought that communication systems needed to be improved and they required more support to deliver good care. They felt that the lack of permanent staff and high staff turnover had raised issues. Their comments included, "Staff leaving and not showing up for work has been really difficult, we don't always know who is supposed to be on duty."

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health. However care plans did not include all the information about people's health related needs.

People were protected, as far as possible, by a safe recruitment system. Each staff file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by St Dominic's Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC), which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

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

St Dominic's Nursing Home was not safe.

Risk assessments, whilst in place were not always up to date. The management of people's individual safety was poor and placed people at risk. People were placed at risk from pressure relieving equipment which was not suitable for their needs.

There was not always enough suitably staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

The management and administration of medicines was not always safe.

Not all staff had received training in how to safeguard people from abuse and not all staff were confident about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Inadequate

St Dominic's Nursing Home was not effective.

Meal times were a solitary and inefficient service with food being served to people who were asleep or left with their meal untouched in front of them. Nurses had no oversight of how much people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy, specifically people who live with diabetes.

Some staff had not received training on the Mental Capacity Act 2005. Mental capacity assessments were not completed in line with legal requirements. DoLS had not been submitted for all of those who were deprived of their liberty.

Not all staff had received training to carry out their roles effectively. Safe care delivery was not consistent throughout the service. The lack of safeguarding training meant that staff were not confident of how to raise concerns.

Not all staff received on-going professional development through

regular supervisions, and the lack of effective induction processes for agency and new staff was a concern.

Is the service caring?

Inadequate

St Dominic's Nursing Home was not caring.

People were positive about the care they received, but this was not supported by some of our observations.

Care mainly focused on completing the task and did not take account of people's individual preferences and did not always respect their dignity. People who remained in their bedroom received very little attention.

Staff did not always interact positively with people throughout our inspection.

Is the service responsive?

Inadequate

St Dominic's Nursing Home was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care. The management of behaviours that challenged were not always managed well.

Some people told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home were isolated. This was confirmed by discussions with people.

Is the service well-led?

Inadequate

St Dominic's Nursing Home was not well led. People were put at risk because systems for monitoring quality were not effective.

The provider had a vision and values statement, however staff were not clear on the organisation's direction. Staff however told us that they felt unsupported by the management team and let down by staffing levels.

People had an awareness of who the manager was but not everyone could tell us they had met the manager and were aware of them.

St Dominic's 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 9, 12 and 14 September 2016 and was unannounced. The inspection team consisted of three inspectors.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the Quality Monitoring Team- (social services placement team) and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. As we were responding to concerns the PIR was not requested for this inspection process.

During the inspection, we spoke with 18 people who lived at the home, five relatives, the manager, operational manager, three registered nurses, seven care staff and the maintenance person. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms and the lounge.

We contacted healthcare professionals who visit the service. This included the community dieticians, speech and language therapists and tissue viability nurses. We spoke with two healthcare professionals from a local GP surgery, a GP and community matron. We also had feedback from the Quality Monitoring Team.

Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records which included quality assurance audits, staff training schedules and policies and procedures. We looked at ten care plans and the risk assessments included within the care plans, along with other relevant documentation to support our findings.

We also reviewed the care pathways of people living at St Dominic's Nursing Home. We looked at the care delivery on the day of inspection and obtained the people's views of the care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I feel safe here" and "I think I'm safe, I can tell someone if I feel unsure." A visitor told us, "Staffing problems I think, because I see new faces a lot." A relative told us, "I feel they are in safe hands most of the time, but I have concerns about staffing." Although people told us they felt safe, we found examples of care practice which were not safe.

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. St Dominic's Nursing Home was divided into six units over four floors and there were two staff teams to cover 24 hour care. The lower ground floor accommodation provided care and support specifically for those who lived with dementia. The staffing teams were separated into four teams during the day and three teams at night.

On the first day the staffing numbers were not as predicted and were short by two registered nurses (RN's) and three care staff. One night care staff member had agreed to stay on until 11am. The registered manager who was a registered nurse worked on the first floor until a replacement arrived. There was no RN on the dementia Unit (Fern). We were told the RN would be in at 9am until 11am. However the RN was also the tissue viability nurse and therefore did not spend sufficient time on Fern Unit directing and supporting the care staff. One care staff member said, "I don't know who is in charge today, we just get on with it."

The staffing shortages were not confined to just the first day and we were informed that it was an on-going problem at this time due to staff leaving. There was a reliance on agency staff to complete the numbers. The lack of staff numbers did impact negatively on the outcomes for people. People did not receive the level of personal care to meet their needs. Personal care is washing, changing of clothing and oral care. Staff told us that due to the lack of staff they had not been able to give people the showers or assisted washes that they were required to have. One staff member said, "It's not fair on our residents, but if staff don't turn up what can the manager do?" We asked staff if they felt the staffing levels were sufficient to provide safe care. They felt it was unsafe.

The staffing levels at night were not sufficient to ensure people's safety and well-being. The staffing levels at night on all four floors were two RN's and seven care staff. The RN on Dahlia and Crocus told us he was responsible for two floors, 31 people and had three care staff. It was admitted that this was not sufficient to manage an emergency situation. One night staff care member said, "It's really hard work, I have to keep calling for help as most people need two staff. The morning is terrible, we can't make sure everyone is clean and comfortable because the nurse is busy with some medicines." We observed three people at 7.45am who were in a distressed state as staff had not yet been able to respond to their needs. One person's bed was wet and they had pulled the sheet away and were sitting on the plastic mattress. We immediately informed the nurse in charge who said, "Staff will be back in a minute they are collecting the breakfast trolleys." It took 20 minutes for staff to attend to this person's needs.

The provider had not ensured that there were sufficient, staff to meet peoples' needs and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and an overall dependency profile of each person. They looked at the identified risk and included a plan of action. However, some risk assessments did not always include sufficient guidance for care staff to provide safe care and others were not being followed. For example, one person admitted for a short stay had a risk assessment/care plan in place that identified that the person had known kidney problems and needed 2.5 litres of fluids a day to protect their health and staff were to monitor their urinary output. This had not happened and on some days during their stay the fluid chart only showed up to 250 mls taken with no urine output documented. The GP had not been contacted for advice. This person had diabetes which was controlled by diet and tablets. The admission document stated that regular blood sugars needed to be taken to ensure that the person's health was maintained. The care plan did not reflect that this person had diabetes; there were no care directives for staff to follow and no blood sugars had been taken since their arrival at St Dominic's Nursing Home. This person's blood sugar on the 8 September 2016 was recorded by a paramedic crew as 2 mmols, which is below the normal range (3.9 mmols-5.5 mmols). Staff had not assessed the risks to the health and safety of this person whilst they received care and treatment.

Infection control measures had not ensured people were protected from potential cross infection risk. Staff had not followed the National Institute for Health and Care Excellence (NICE) good practice guidelines in caring for catheters. Catheter tubing was attached to re-usable urine drainage bags uncovered in unclean bathrooms. This could cause a bladder infection to the person when reconnected to the person's catheter. The equipment used for cleaning (mops) was grubby and did not follow a colour code system used to differentiate between areas such as toilets, bedrooms and communal areas. The cupboard used to store cleaning products was unlocked, overcrowded and disorganised. Commodes and commode pots despite going through an industrial washer were not clean but were still in use. We raised concerns about fabric chairs on Fern Unit that were dirty and had an unpleasant odour. Staff told us that they had asked for them to be cleaned and were still waiting. We checked the maintenance book but could not see that this had been reported as requiring attention. There were strong odours of urine in five bedrooms and in two corridors that had not been identified by staff and reported to the cleaning team.

We were not assured by the emergency evacuation procedures in the home. The personal emergency evacuation plans (PEEPs) were generic and did not change for decreased staffing levels at night. The PEEPs did not include the information necessary for staff to follow to move people quickly and safely. Some identified that a hoist was needed and two staff or wheelchair but these could not be used for a fast evacuation and at night due to decreased staffing levels. This may potentially slow an emergency evacuation and place people at risk.

The signage for emergency exits in the home was not clear and missing at the bottom of one flight of stairs. The service had emergency evacuation slides to use on stairs but only two were in place for 91 potential people living in the home, four floors and five staircases. Staff had not had training in using the evacuation slides and staff were not confident in how they worked. Whilst fire extinguishers were located throughout the building, training in using them safely had not been undertaken by staff. Fire doors were not all functioning and we asked that this be addressed immediately. This was actioned by the end of the day. We asked that advice was sought in respect of fire doors, fire exits and evacuation plans from the fire service as a matter of priority.

We were aware of actions outstanding from the pharmacist who had undertaken an audit on the 6 September 2016. Our inspection identified that there were still areas that needed action and we asked that these were progressed immediately to reduce the risk of unsafe medicine practices. This included the lack of signatures or dates of discontinued medicines, lack of details of amount of as required (PRN) medicines

given, expired medication in the controlled drug cupboard and poor record keeping of the controlled drug record book. The medicine rooms were cluttered and disorganised and records of the medicine fridge and room temperatures were not completed consistently. This meant staff could not be assured that the medicines were being kept at the right temperature for safe administration.

All of the above issues demonstrated that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being given in the morning and lunchtime and saw that RN's administered medicines safely. RN's who administered medicines carried out the necessary checks before giving them and ensured that the person took the medicines before signing the medication administration record (MAR) chart. The RN ensured medicines were swallowed before signing the MAR chart and ensured the trolley was locked when not in use.

The training schedule identified that not all staff had received safeguarding training and staff confirmed this. Not all staff had a clear understanding of abuse and they were not aware of the safeguarding procedures to ensure people were protected. Safeguarding policies and procedures were in place and were up to date and appropriate. The registered manager had received training in safeguarding adults at risk and was able to tell us of the signs of abuse, and since her arrival safeguarding referrals had been made to the local authority when required. It was acknowledged that there had been some incidents/accidents that had not referred to the local authority for investigation. These were now being investigated.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview before they started work, that the provider obtained references and carried out a criminal records check. We checked eight staff records and saw that these were in place. Two were not in the file, but we received information following the inspection that they were in place. Each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed by St Dominic's Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." and "The carers are very good." However, we found St Dominic's Home did not consistently provide care that was effective.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS forms part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS ensures that the least restrictive methods are used.

The management team kept a list of DoLS authorisations submitted, However it was not current or accurate. It listed people who had left St Dominic's Nursing Home and did not confirm when a DoLS had been re-applied for. There were three people on Fern Unit who still needed a DoLS application to be submitted, because restrictive practices such as locked doors, recliner chairs (which restrict freedom of movement) and bed rails were used. We also observed that one person on Fern Unit was trying to get out of the locked corridor on the unit. This did not meet with the principles of DoLS. We saw on two other units that recliner chairs were used for people who were able to walk but not able to operate the chair to allow them to stand. One person on Astor Unit was restricted to bed by bed rails, but the care plan stated following a fall over the bed rails, bed rails were not to be used. The risk assessments in place did not always consider if people were able to consent to these measures or whether a less restrictive practice could be used, for example pressure mats or door monitoring alarms.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. However, it was evident that some people were at risk from self-neglect as they did not always agree to personal care. The MCA states that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. This told us mental capacity assessments whilst undertaken were not decision specific and were not recorded in line with legal requirements. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people, staff and visitors about the food was varied and ranged from "Good and hearty" and "not bad" to "Inconsistent." We observed the midday and evening meal service on four floors over the three days. Meals were delivered to the units in hot trolleys and staff served the meals individually. On the first day the meals were not attractively served. One person was served lentil stew pureed and did not look appetising. This person did not need a pureed diet. When the person queried what it was, staff were unsure and went to find a menu. When the person said they didn't want it, staff placed mash potato, broccoli, carrots and gravy on top. This meal was uneaten by the person. The person was not offered another option and was instead offered a pudding. This was not an isolated incident during the inspection and occurred on three of the six units. On Fern Unit staff were too busy delivering food to give individual assistance to people and we observed people struggling to eat their meal. For example people were attempting to eat chips with

a spoon. People then became frustrated and distressed which disturbed other people. Staff then took the meals away uneaten and replaced these with a pudding.

People were offered a drink but on three occasions the drink was removed without being drunk. Food and fluid charts were not always accurate and were not completed consistently. We saw staff had written 'eaten all' referring to the lunch we had observed refused. Where people's drinks had been taken away without being touched, staff had written 250 mls tea.

The food and fluid charts identified that some people had not received food or drink after 5:30pm until 7am the following day. This identified that people had gone over 12 hours without food or fluids. Staff told us how they monitored people's food and drink. One care staff member told us, "We fill in people's food and fluid charts every day." On the day of our inspection we found some people's fluid and food chart had not been completed. Staff did not have an accurate oversight of people's nutritional and hydration needs. People were therefore placed at risk of dehydration and malnutrition.

There were people who remained in their room for their meals. We saw staff serve meals and then leave them in front of people until staff were free to assist. On two separate occasions, staff did not return for 15 minutes. In the lounge area of Crocus and Dahlia Units two people were left waiting without meals for 40 minutes whilst other people had finished their main meals and desserts. When they were assisted with their meal it was not an inclusive or consistent. Different staff took over during the meal time and had a different approach. This resulted in the people not eating the whole of their meal.

We were not assured that people received suitable and nutritious food and hydration which was adequate to sustain life and good health. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff training schedule identified that not all staff had completed essential training for delivering safe care. For example safeguarding, fire training, moving and handling and health and safety. Five registered nurses (RN's) had not completed safeguarding, fire, first aid and infection control training. It was of particular concern that registered nurses had not received fire training since 2014. Due to the concerns we had about the delivery of the care, we were not assured that the training was being followed or put in to practice.

Not all staff had received on-going support and professional development. Supervision schedules and staff confirmed they had received regular supervision but there had been a lapse due to key staff leaving employment. The registered manager produced a supervision programme which confirmed that supervision sessions were planned for the future.

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

External health care professionals had visited the service, such as GP's, speech and language therapists, chiropodists, opticians and the district nurse. The staff recorded health professional visits in individual care plans. People we spoke with were happy with the health care support they received. One person told us, "We have a chiropodist and optician, I think they come and visit every so often. The dentist and GP visit as well."

Inadequate

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, and therefore there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact who were given very little time and attention throughout the day.

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain people's dignity. Our observations identified that verbal interaction was minimal and staff lacked empathy with the people they supported. We saw examples where people were isolated both in their bedrooms and in communal areas. The only time people saw staff was when a 'task' was undertaken. Staff said, "I know it's not good enough, we are short staffed so we don't have time" There was a lack of engagement between staff and people due to the staff shortages. When a person was talking loudly, the staff member said, "I will finish feeding you later." They did not return to finish assisting the person with their meal for 45 minutes. This was not respectful or dignified.

People were not always treated with dignity and respect. We heard a person calling 'help me, help me in a distressed manner. There were no staff visible so we knocked and entered the room. The person told us "I've been calling out for help for ages, please help me." The person needed urgent personal care. The call bell was not in reach and the bed rails prevented the person from getting out of bed. We called for staff who arrived after approximately eight minutes. They went to find another staff member to assist them to help the person. The person was able to use a call bell but had not been given access to a call bell. The care plan stated the person became really upset when incontinent and staff were to ensure they supported the person to be continent by regular assisting the person to the bathroom. This had not happened on this occasion.

On Aster Unit we found that there were some people whose beds were facing away from the door and they couldn't see who was entering their room or see people in the corridor when in bed. One person who remained on continuous bed rest had no visual stimulation in their eye view in their room. Pictures of dogs were hidden by curtains and other personal effects were behind them. There was no television or radio in their room for company or to engage their interest. Staff said they didn't engage very often now. We asked staff and the management team why these beds were placed in that position but no one knew why. The placement of the beds had increased the potential of social isolation. We spoke with a member of the management team who assured us that this situation would be attended to. We visited the person again the next day and saw that the bed had been moved so the person could see staff and visitors entering their room. They could see their personal photographs and was smiling and interacting with us whilst we spoke about their photographs.

People's preferences for personal care were recorded for each person but not always followed due to staff being rushed. Documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in 14 days. A staff member said, "We do our best, but we are not able to spend quality time due to the staffing levels." The sample of daily notes and personal care check list we looked at were not consistently completed. Visitors shared concerns that baths and showers were not

being offered. Care staff commented that most people received a wash and confirmed that people were not offered a regular bath or shower due to staffing issues. Due to these factors, we could not be assured that people's personal hygiene needs were being met as they required.

The communal areas and corridors on Fern Unit had been designed to be dementia friendly and homely. However some ideas whilst started had not been finished. For example in corridors there were painted window frames that were to be personalised to help people find their room. However this had not progressed in two years and had been left as a blank window. The main lounge on Fern Unit was divided into three areas with dining tables at one end, two rows of chairs in the middle facing a television. A further area was being used as a quiet area. Whilst it was light and airy, the communal area was lacking in atmosphere; people sat in silence whilst another sat at one end with minimal support offered. There was a lack of accessible sensory equipment for people to prompt memories or encourage mental stimulation. This meant the environment was not a caring and stimulating for people who were living with dementia. People were isolated, despite being with other people.

People's independence was not always promoted. In the lounge people spent a considerable amount of time without staff being present. There were people who could request attention, however these people had no access to a call bell to summon assistance. We asked one person how they called for staff, they said, "I wait till I see someone." We spoke with another person who told us, "I can go for hours without seeing anyone, but I have my bits and bobs, so I keep myself amused, but the days are long." Comments from other people included, "I don't get any choices anymore, I just accept what happens," and "Staff try but they are just rushing about all the time so it's easier to just go along."

We spent time with one person who had recently moved in to the home, on arrival they had been able to walk but had since become reliant on staff to move them with a hoist. Staff were unable to tell us why the person's mobility had decreased. We looked at the care plan and risk assessments which mentioned that they had been found in a corridor during the night but no further comments about their mobility. There was no reference to encouraging them to walk with assistance or of exercises to keep them moving.

During lunchtime we observed some good interactions between staff and people they were assisting with their meals on Bluebell Unit, but this was missing on the other units. On Bluebell Unit staff chatted with people whilst sitting alongside them. However, on other units staff did not talk to the person while helping them eat and there was no eye contact. This was specifically noted with those who lived with dementia. They occasionally referred to the person by name and put food or drink in their mouth or in front of them without describing or explaining what it was.

People were not consistently treated with dignity and respect and they were not encouraged to be independent or to live a life of their choice. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see some staff interacting with people in a kind and compassionate way. They talked about wanting to make changes and were committed to their job.

Inadequate

Is the service responsive?

Our findings

Whilst some visitors told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to peoples' individual needs.

Communication and social well-being was an area which we identified as a concern. This was because a large amount of people were isolated in their bedrooms, and in the lounge areas, with little interaction from staff. During our inspection we noted at times there were no staff in communal areas and people were left with the television on in the background. There was no rationale given by staff or any evidence this was people's choice. One person said, "I don't watch it because it's not what I want to watch." There were also people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed tasks but they did not use this one to one time to chat or offer reassurance. The SOFI identified that there was little empathy shown by staff to people and very little positive conversation.

Care plans reflected some people's specific need for social interaction, for example, "Enjoys puzzles and likes to socialise" but these were not being met consistently. We were told by staff "Because staffing is difficult the activity people are helping out with drinks and supervising the lounges so activities aren't happening as they usually are." We visited seven people regularly throughout our inspection and saw they received little social interaction from staff, apart from being given drinks and their meals. We observed staff waking one person for their lunch meal and they soon dozed off again without eating. We looked at the person's room care plan. It did not contain any information of how to interact or what they may enjoy whilst remaining in bed. The hourly interaction chart entries for one person stated only, breakfast offered, tea offered, personal care, lunch offered, resting, resting, supper offered for 24 hours.

There were three activity staff responsible for co-ordinating activities for everyone.. The displayed activity sheet described a variety of activities including exercise sessions and visiting entertainers. None of these took place over the three days of the inspection. Care plans in individual care files mentioned life histories and preferences, they did not contain any specific identified social need, such as talking books or music. There was no reference in their care plans for one to one sessions undertaken, how the sessions went, whether it was beneficial and if an alternative activity might be tried. The activity team kept a log of who attended and how activities were received.

Activities promoted were not fully reflective of people's individual interests and hobbies. One person told us that trips out would be good but it was not clear from talking to staff if outings were offered or planned. One staff member said "One or two people go out regularly, but on their own not with staff. " A visitor told us "The staff are lovely but don't think of taking them in to the garden, I expect they are too busy and the garden is really overgrown now."

People's continence needs were not always managed appropriately. For example, one person's continence plan had guidance in regard to catheter care. However there was no guidance for staff to follow in regard to

keeping it clean and observing for signs of infection. Staff told us that they had not had any training of caring for catheters. We saw evidence that staff were not following good practice guidance in respect of people's catheters. Another person was to have a specific amount of fluids to ensure their catheter was kept clear of debris but this was not followed by staff. This person subsequently developed an urinary tract infection.

The evidence above demonstrates that delivery of care in St Dominic's Nursing Home at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format such as large print or pictorial. We received differing views on the complaint response, which were discussed with the provider. One visitor told us "I have been to the office but I'm not sure I have been taken seriously." Another visitor said, "I am not confident that I can raise any concerns or grumble and the team ensure it's dealt with." There had been a number of complaints received in the past few months and documentation confirmed complaints were investigated and feedback was given to the complainant. However one visitor said, "I'm not satisfied with the response." We were therefore not assured that the providers' complaint procedure was fully established and operated effectively..

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished. Where married couples were both living at St Dominic's Nursing Home, staff did ensure that they visited each other.

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated.

We were told that satisfaction surveys had been sent out in the early part of 2016, and the responses from family and friends were mainly positive. The operational manager told us that the feedback had been used to improve the meal delivery and the activities provided. However these improvements had not been sustained and consistently delivered. This was due recent staff changes including the management team and the high use of agency staff. We were told further surveys would be sent out when changes were settled. One visitor said, "I give feedback all the time, don't wait for a survey."

Inadequate

Is the service well-led?

Our findings

The feedback from people, staff and visitors about the leadership in the home was varied. Comments from visitors included, "New manager, so it's a bit unsettled," "A lot of agency staff, staff have left over the past few months and that is a worry," and "I worry because staff leave and I know that the staffing levels are not right." Staff said, "It's a bit of a struggle, because staff have left, and other staff don't turn up for the shift, but we have a new manager and new staff are being recruited."

There was a registered manager in post. The registered manager had transferred from another service within the organisation. The registered manager was in their third week at St Dominic's Nursing Home.

Organisational quality assurance systems were in place, however they were not all fully up to date and had not identified the shortfalls we found. Therefore the quality assurance systems were not effective. We found significant shortfalls in the cleanliness and maintenance of the home. We were particularly concerned about the maintenance of the fire doors. The audits completed had not identified these and therefore had not ensured that people were safe from the risk of cross infection or fire evacuations.

The provider's systems for audit had not identified a wide range of areas. These included people's safety being potentially at risk as some care plans were lacking in specific information, which had the potential to cause harm to the individual. The overview of people's weights identified significant weight loss for six people, one person's weight loss in three months was 20kgs and another person's weight loss was 15kgs over two months. We asked that these were investigated immediately. The investigation identified that the weights recorded were for the previous occupant's of the room and not the new persons. This was of particular concern as staff had not identified this as inaccurate and had not taken any action.

The care plan audits had not identified care omissions or inaccurate treatment. For example, one person who lived with diabetes had conflicting management plans in place. The person had been admitted to hospital twice in the last eight months with high blood sugars (ketoacidosis). The management of the persons' diabetes was not responsive to changes to their blood sugars and recent urinary tract infection. One care plan stated the person was on insulin following discharge from hospital. Staff said that this was not correct as the insulin had been stopped by the GP. The second care plan stated that the person diabetes was managed by tablets and diet. We looked at the blood sugar readings for the past two weeks and noted that the person's blood sugars were high and documented at 23 mmols for some days which was considered a risk. Staff had not responded to this by informing the GP in a timely manner.

The audits undertaken by the provider had not identified significant staff training shortfalls. It was difficult from the training programme to ascertain if care staff had received moving and handling training as there were no dates of training recorded. Fire training for staff was out of date by up to two years and very few staff had attended safeguarding training. These are essential training for all staff. We also noted that the training matrix was not reflective of the staff employed by the provider. For example it still contained names of staff that no longer worked at St.Dominic's Nursing Home.

We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink. The provider's care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of diabetes, behaviours that challenged and continence.

Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not effective and people's records were not always accurate and had not reflected changes to their health and well-being. People therefore had not been protected against unsafe treatment by the quality assurance systems in place and this was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. Staff told us that they felt unsupported and that the management team were not always approachable and visible. Staff said that they felt their careers were at risk because of the lack of communication and unsafe staffing levels. One RN said, "I worry all the time, I'm not supported and encouraged in my role, I have asked for guidance in care planning but was told to get on with it."

Staff we spoke with did not yet have an understanding of the vision of the home. From observing staff interactions with people it was clear the vision of the home was not clear as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff. This told us that the culture of the home had to change to ensure person centred care was delivered. Staff also told us that staff had left the service and they felt stressed because of staff changes. The management team confirmed that staffing over the past six months had been a challenge. They were continuing to recruit and were advertising for clinical leads and a deputy manager.

Communication and leadership needed to be improved within the home. People and visitors had an awareness of the management team but felt that staff turnover and use of agency had unsettled the running of the home. Due to staff deployment and high use of agency staff we saw that poor practice was accepted by staff. We saw shortcuts in care delivery such as not moving people in a safe way and not supporting them adequately with meals and drinks. People therefore did not always receive the care they wanted and required.

We spoke with staff about how information was shared. They told us they were given updates but felt they "Were too quick and didn't really tell them much." They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, new handover sheets and supervision. However handover sheets were not up to date and were not detailed.

During the inspection we raised concerns that the management overview of the service was not up to date or accurate. The registered manager was learning about people and staff but was having to cover staff shortages as well as manage the service. There was no extra support for her in place at this time. The operational manager told us that there were plans to recruit clinical leads and a deputy to support the management team.

The operational manager told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I

have been worried because there seemed to be a lot of changes, but things seem to be going forward, I hope they get things sorted."

Staff meetings had been held regularly over the past six months, and we were assured that regular meetings would be held whilst changes to the management structure continued. The manager said, "There is a lot to do, a lot to put in place and changes to make, such as the culture, but we will get there."

The service had not always notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.

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 had not ensured that service users were treated with dignity and had their privacy protected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

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 Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 14 HSCA RA Regulations 2014 Meeting

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision.