Bupa Care Homes (CFHCare) Limited

Monmouth Court Care Home

Inspection report

Monmouth Close
Ipswich
Suffolk
IP2 8RS

Date of inspection visit:
07 December 2016
08 December 2016
12 December 2016

Date of publication:
08 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place over three days, on the 7, 8 and 12 of December 2016.

Monmouth Court Nursing Home provides care and support to a maximum of 153 older people, some of whom were living with dementia and or had complex nursing needs. People were accommodated across three units, with a fourth unit being closed at the time of our inspection. At the time of our visit there were 58 people living at the service.

At our previous inspection in December 2015 the service was rated as 'inadequate' and so placed into special measures. This was because we identified major shortfalls with breaches of regulation regarding the lack of action taken to mitigate the risks to people, insufficient numbers of suitability, qualified and experienced staff available at all times to meet people's complex health care needs and the monitoring of the safety and quality of care provided to people across all three units at the service. This was linked to a lack of clinical oversight and effective leadership and support from the registered manager and the provider. In response to our findings we asked the registered manager to take urgent action to protect people from harm. We took urgent action by placing conditions on the provider's registration including the restriction of any new admissions to the service.

At this inspection we found some improvements. However, there was a need for further development of the service. We identified continued shortfalls in relation to people having access to sufficient numbers of, suitably qualified staff at all times to meet their needs and in the training, development and deployment of staff to meet the needs of people living with dementia. There continued to be a high number of nursing staff vacancies which meant there continued to be a high number of agency nurses employed. This impacted on the effectiveness of communication and the consistency of care provided to people to ensure their health, welfare and safety needs were met.

Since our last inspection the registered manager had left and a new manager appointed in August 2016. There is a requirement for this service to have a manager registered with the Care Quality Commission (CQC). The manager told us they had completed their application to register but their application was currently with Bupa's legal team for review before submission to CQC. 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.

People and their relatives were positive about the change in management and responses to any concerns and or complaints they had raised with the provider. There were improved systems in place for continuous quality and safety monitoring of the service including clinical oversight of the service.

The provider had improved systems in place for identifying risks to people's health, welfare and safety. We found some improvement had been made with systems now in place to ensure the safe management and

monitoring of people's nutrition and hydration needs, in particular for people with swallowing difficulties, those at risk of choking and people at risk of insufficient intake of nutrition and hydration. However, risks that had been identified were not always consistently managed.

At our previous inspection we identified major shortfalls in the safe management of people's medicines. At this inspection we found significant improvement. However further work was needed as we found inconsistencies in the management and recording of people's prescribed creams and lotions. Staff were not always provided with clear information as to where on the body and how often the creams and lotions should be applied.

The provider had systems in place and staff trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow. However, we found risks to people's health, welfare and safety were not always effectively managed. There continued to be a high number of nursing staff vacancies. There was not to always sufficient numbers of skilled and experienced staff available to provide consistency of care which met people's needs.

We observed some very caring interactions between staff and people living at the service. Relatives were positive about the improvements they had observed in the culture of the staff group. Staff were observed in the main to be kind and respectful but care delivery on Harlech unit was often task focused as staff had limited time to spend with people. This included the number of staffing hours allocated to those staff employed to provide social stimulation, including group activities and so staff were not always able to meet the holistic, individual needs of people living with advanced dementia.

We found inconsistencies in the quality of care planning to guide staff in the steps they should take to meet people's needs. Care plans did not always reflect the current needs of people and contained limited information as to people's preferred wishes and preferences about how they would like to live their day and support that should be provided to enable them to do this. There was a lack of provision of support to enable people to maintain their hobbies and interests as much as they are able. People were not always protected from the risks of social isolation. There were a high number of people who stayed in bed. It was not always clear within their care plans as to why this was the case.

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

Requires Improvement

The service continued not to be consistently safe.

There were not always sufficient numbers of skilled and experienced staff available to provide consistency of care which met people's needs.

Staff demonstrated a good understanding of how to recognise and report any signs of neglect and abuse. Risks had been identified but were not always consistently managed.

There were systems in place to ensure the safe management of people's medicines. However, medicines were not always managed appropriately.

Is the service effective?

Requires Improvement

The service continued not to be consistently effective.

Staff had received appropriate training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005.

Further work was needed to improve the meal time experience for people living on Harlech unit. There was insufficient staff available at meal times which impacted on people's dining experience.

Staff did not always monitor and record the correct amount of food people at risk of inadequate food intake consumed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were observed in the main to be kind and respectful but care delivery was often task focused, and did not always meet individual needs.

Care plans contained limited information as to people's preferred wishes and preferences about how they would like to live their day and support that should be provided to enable

them to do this.

We found on Harlech unit a lack of recorded life histories which is recognised as good practice.

End of life wishes and preferences were not always appropriately recorded.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found inconsistencies in the quality of care planning to meet people's needs. Care plans did not always reflect the current needs of people, reflecting their choices and preferences as to how they chose to spend their days including provision to support people to maintain their hobbies and interests as much as they are able.

People were not always protected from the risks of social isolation. There were a high number of people who stayed in bed. It was not always clear within their care plans as to why this was the case.

People had access to clear information about how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led because we remained concerned at the length of time it took for the provider to make available resources to enable the manager to respond to identified risks to people's welfare and safety.

People, their relatives and staff were positive about the appointment of the new manager.

There were improved systems in place for continuous quality and safety monitoring of the service including the clinical oversight of the service.

Monmouth Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place over three days, the 7, 8 and 12 of December 2016 and was unannounced.

The inspection team was made up of four inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience of providing care and support for an older person.

Prior to our inspection we reviewed the previous inspection report to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

Some people living at the service were unable to tell us, in detail, about their experiences of how they were cared for and supported because of their complex needs. However, we spoke with 11 people who were able to verbally express their views about the quality of the service they received and six people's relatives. We also spoke with one visiting healthcare professional.

We observed the care and support provided to people and the interactions between staff and people throughout the three days of our inspection. We also carried out a Short Observational Framework for Inspection (SOFI). SOFI is a tool used to help us assess the care of people who are unable to communicate to us their experience of the care they received.

We looked at records in relation to nine people's care. We spoke with the manager, the clinical services manager, the deputy manager, and two regional managers. We also spoke with, five nurses, the cook, one activities coordinator and eight members of care and domestic staff.

We looked at records relating to the management of medicines, staff recruitment, staff training and systems for monitoring the quality and safety of the service.

Prior to and during our inspection we spoke with stakeholders such as the local authority and visiting health care professionals.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2015 we identified major shortfalls because risks to people's health, welfare and safety had not been fully identified and guidance provided for staff with steps they should take to mitigate these risks.

The provider had systems in place and staff were trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow. The manager had been proactive in reporting safeguarding concerns to the local safeguarding authority for investigation. Staff demonstrated a good understanding of how to recognise and report any signs of neglect and abuse.

We found on Harlech unit, a unit designated for people living with dementia, that there was not always enough staff around to be able to detect where people who had been identified as at risk of harassment from others were located. For example, during meal times when staff were busy serving meals and supporting people to eat their meals, they did not notice when people had become distressed at others entering their rooms and so were not available to intervene to protect people already identified as at risk.

Records showed the manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. Where people had a high number of incidents of falling we saw the falls team had been involved, a falls assessment had been carried out, and falls risk assessments had been updated and observation charts had been put in place.

Risks had been identified but were not always consistently managed. We observed one person moving around the lounge area within Harlech unit, walking unaccompanied and attempted to sit in an already occupied armchair and subsequently fell to the floor. The nurse in the glass fronted office had observed the situation, but did not immediately go to support and offer assistance. Care staff eventually came with a hoist and began to apply the hoist straps. We observed and informed staff that the left leg strap was twisted as staff began to raise the hoist. Staff then responded, undid the strap and attached it correctly. The padded leg straps are designed to cover most of the leg area and support the leg when being raised, if it is twisted the strap becomes smaller and will not support as designed, the strap also becomes narrower and will press into the leg causing discomfort and pain.

Later in the afternoon we observed again the same person fall onto the floor outside the unit office. We intervened again and requested staff assistance. We were told that this person required one to one support as they were at constant risk of falls. Although action had been taken to request funding for one to one support from the clinical commissioners, this had been declined and the provider had served notice as they said they could no longer meet this person's needs. However, the provider had failed to take action to instigate the one to one staff support at all times whilst an alternative placement was found. This continued to put this person at risk from a lack of constant supervision and potential injury. We also found where

equipment such as a chair sensor had been provided this had not been turned on during the first day of our inspection until we informed staff of this. We noted that their care plan stated that an alarm or sensor mat is required to alert staff in the prevention of falls. We also noted a four wheeled walking aid was being used as a means of transportation by staff and was not designed for use as a wheelchair, as it has no footrests to keep a person's feet clear of the floor. This had the potential to cause injury to the feet and legs if they are not clear of the floor whilst being mobilised.

We found moving and handling equipment such as hoist slings inappropriate for the assessed needs of people. Where people required hoist slings allocated for their personal use to avoid the risk of harm from inappropriate size of sling and cross infection, we found one sling in use for a number of people. The management team had identified this as a risk and had requested in October 2016 financial approval from the provider to purchase slings for each person. On the first day of our inspection we questioned why this identified risk requiring the provider's approval for resources to eliminate this risk had not been responded to. We discussed this with the management team including the regional manager. We were informed on day three of our inspection our concerns had been responded to and approval to purchase the required equipment had been granted.

We found some gaps in records for a number of people at risk where staff were required to have carried out hourly observation checks. This was where people had been assessed as requiring these checks to monitor their safety and wellbeing. For example, one person at risk of frequent falls the care plan stated, 'Can mobilise but has frequent falls when confused and agitated. Staff to be aware of [person's] whereabouts so that if they need assistance, this can be given appropriately'. We reviewed records where staff would evidence these checks, and found on several occasions these records stopped at 17.20 hrs and 19.20 hrs until the following day. The falls diary for this person also evidenced several falls where this person sustained injuries and staff were not in the vicinity and recorded the fall as unobserved. We noted that one fall described an open wound. We asked the nurse on duty about the action taken in response to the wound and the care plan for this. The nurse told us, "It had been filed away." We asked to view this information. Later in the day the incident form concerning the fall was produced. We asked what the knee had been dressed with as there was no information on the incident form. The nurse told us, "It was not dressed with anything as it was not open." We showed the nurse the photograph taken by staff following the fall and said that the knee showed an open area of skin and asked if a dressing would have been applied to an area like this? The nurse said they were not sure. We expressed our concern that all open wounds should be cleaned first and then covered with a sterile dressing to prevent cross infection, especially as it was sustained from a fall and may have been contaminated from bacteria from the floor.

We reviewed the care of one person with a long term indwelling catheter. The care plan recorded that this should be changed three monthly. There was a recording sheet with the adhesive labels from the catheters used on it; the last date recorded was in October 2016. There was no further information in the care plan to instruct staff as to the next date when re catheterisation should take place. However, we found information on the medication administration record which advised the date set for change, but this was ten days later than recommended. The clinical guidance is that long term catheters can be used for up to 12 weeks from the insertion date. The reason for the 12 week interval is that encrustation is much more likely to occur if the time the catheter remains in the bladder is extended. The catheters are made of material that resist the build-up of encrustation, but will not prevent it altogether. Leaving them too long between changes will increase the risk of blockage; this can cause pain due to the retention of urine and the need for urgent re catheterisation, instead of a calm planned procedure.

The service had systems in place for the monitoring of people who were at risk of constipation which could lead to health complications. However, these were not always managed effectively to monitor people

identified as at risk. It is important to monitor people in a care setting who can be at risk of impacted bowels due to their lack of mobility, complex health conditions and possible poor intake of nutritious food and fluid and in particular people who are cared for in bed. Impacted bowels can severely impact on people's health and wellbeing leading to bowel obstruction and related health complications. Staff gave us conflicting information as to the current system for monitoring people at risk of impacted bowels. Some staff said the Bristol bowel monitoring charts were in use and others who said they were no longer used and that staff were to write any bowel movements into daily records. However, we found that this was not always happening. We noted three people assessed as at risk of constipation and prescribed medicines for this purpose did not have their bowel movements monitored as required with gaps for one person of up to nine days, staff had not identified this as a risk. Staff had recorded in daily records behaviour which may have been due to constipation with a lack of evidence that this had been identified and responded to. We discussed this and the lack of consistent monitoring with the clinical services manager who told us they would take action to re-instate the monitoring charts.

This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Harlech unit, we observed a hot trolley left unattended when staff were required to assist people with serving and eating their meals, leaving the trolley out of their sight. This posed a risk to people from scalding. We observed one person walking towards the trolley and we needed to intervene to prevent them from the risk of harm. We discussed our concerns with the management team. They told us they would take immediate action to either relocate the hot trolley or build a unit around it which would prevent people gaining access. However, on the third day of our visit we were informed that an additional member of staff had been recruited into a meal time hostess role, with responsibility for the hot trolley. This we were informed would enable nursing and care staff to be free of the responsibility of serving meals.

In response to the shortfalls identified at the last inspection where we found people at risk from the inappropriate use of bed rails, the provider had implemented a new bed rails use policy. A review including risk assessment had been carried out of all people with a bed rail in situ. This review had included consultation with people and their relatives where appropriate. Bedside rails are pieces of equipment that are intended to prevent people from falling out of bed and sustaining injury. Where it had been assessed people were at risk of unlawful restraint, entrapment or where people lacked capacity to consent and may be at risk of injury when trying to climb over the bed rail, these had been removed. We saw that in their place and where it had been assessed as safe and appropriate, beds had been lowered to the ground and safe crash mats provided to prevent people from the risk of harm.

Where people had been assessed as being at high risk of developing pressure ulcers, we found improvement in the control measures in place with guidance for staff as to the action needed to maintain their skin integrity. This included guidance for staff as to the regularity with which people would need to be repositioned, the required nutrition to aid recovery and healing of the affected area. Where people required pressure relieving mattress to help manage their skin integrity, we saw evidence that daily checks were made to ensure that the mattresses settings were set at the correct pressure ad in good working order.

People told us, "You do sometimes wait a long time when you call for help. Sometimes they say they are busy and you can be left to wait. The worst time is at 07:00 in the morning when night staff go home and day staff arrive and everyone wants to get up", "They treat me well and look after me but waiting for the toilet is the only problem" and "Staff never seem to stop, you hear call bells going off regularly, it seems people have to wait a while." Relatives told us, "There has been some definite improvement with some staff having left and some nice new staff here now. Every time [relative] rings the bell someone comes but sometimes it

takes some time", and "Sometimes they are quick to answer the buzzer and sometimes not. I have noticed people waiting for five to ten minutes because they are busy."

Staff told us, "The manager is fab, really supportive but we are often short staffed and don't get to spend time with people as we would like. They say we are overstaffed but there has been a lot of sickness. When we are fully staffed and we do our hourly checks on people we can spend time and chat with them but this is not always the case as we run short often."

Staff on Harlech, a unit designated for people living with advanced dementia told us there was insufficient staff available at all times of the day and night. We noted where people had been assessed as at high risk of falls there were insufficient staff to available at all times to prevent them from the risk of falling. For example, one person who we had observed falling and had needed to intervene had been assessed as requiring one to one care. A request for funding to enable the provider to pay for one to one care had been requested from commissioners. We noted that whilst this had been assessed as a need, the provider had not provided one to one staffing to mitigate the risk of harm identified whilst negotiations for this funding were in process. This meant that action had not been fully implemented to mitigate the risk of falling for this person.

Each care plan contained a dependency assessment document which was used as a guide to calculate staffing levels. The manager told us that staffing levels were reviewed on a regular basis to ensure there was sufficient staff available to meet people's identified needs. However, people, their relatives and staff across all the units consistently told us that there were not always sufficient staff, available to support people and provide safe, person centred care. One relative told us, "Sometimes though, I don't think there are enough staff here. They seem to be very short at times when we visit, especially the mornings and weekends."

Staff across the service told us that at times they felt rushed, that care was task focused and that they found it difficult to safely observe all of the people who required close monitoring, especially those people living with advanced dementia and at risk of falls. Staff on Cilgarren unit told us there was insufficient staff available at night to meet the needs of people who required two staff at any one time to assist with mobilising using a hoist, repositioning to maintain skin integrity and support with their personal care. We discussed this with the provider who told us that in response to Cilgarren unit funding was agreed immediately following our inspection to employ an additional member of staff at night and on Harlech to provide additional staff during meal times.

There continued to be insufficient numbers of skilled and experienced staff available at all times to ensure people received consistency of care which met their health and welfare needs. The manager told us there was currently 215 weekly nursing staff hours vacant of which 137 hours were vacancies for night nurses.

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

At our previous inspection we identified major shortfalls in the safe management of people's medicines. At this inspection we found significant improvement. People's medicines, including controlled medicines, were stored safely and there was a system for the ordering, receipt and disposal of medicines. The provider had implemented daily audits which included a check of stock against the medication administration records (MAR). This system identified errors in a timely manner with evidence of action taken in response recorded. We saw that controlled drug records were accurately recorded. The administration of the medicine and the balance remaining was checked by two appropriately trained staff. Each person's (MAR) contained a photographic record of them and there was detailed medicine and allergy information.

Staff told us they had received updated training in medicines management and also the use of specialist equipment. However, we found not all nurses had received up to date training in the use of syringe drivers to enable them to administer pain relief medicines to people at the end of life.

We carried out an audit of stock where we found that apart from one item of medicine all 10 people's medicines we reviewed stock tallied with MAR records. However, we found medicines were not always managed appropriately. We found one person asleep with a pot of medicines left in front of them at 20:30. A review of records showed us these medicines had been administered at 17:00. Whilst we went to alert the nurse on duty this person woke up and attempted to take their medicines. We looked at the MAR records in relation to this person's prescribed medicines and found that without sufficient time between taking their medicines they could be at risk of harm. This persons care plan contained inconsistent information as to their capacity to take their medicines unobserved and to guide staff as to how their medicines should be managed safely.

We found inconsistencies in the management and recording of people's prescribed creams and lotions. We reviewed the administration of creams and lotions prescribed to protect and heal damaged skin but could not evidence that this had always been provided as prescribed. Staff were not always provided with clear information as to where on the body and how often the creams and lotions should be applied. For example, some administration records stated, 'should be applied to affected areas' but did not state what areas of body this referred to. Administration records were found in some but not all bedrooms. When we asked a nurse to locate these records they found some had been filed away and were not available for staff to record if and when administration had taken place. This meant we could not be assured that people had received these medicines as prescribed.

We found the MAR record for one person did not contain a prescription for any type of local anaesthetic lubricant for the insertion of the indwelling catheter. This is essential to provide local anaesthesia and lubrication during re-catheterisation. A catheter has to pass along the length of the male urethra and this can be painful without lubrication and very difficult if there is an enlarged prostate. The National Institute of Clinical Excellence (NICE) guidelines April 2014 state, 'An appropriate lubricant from a single-use container should be used during catheter insertion to minimise urethral trauma and infection.' We discussed this with the clinical services manager on the first day of our inspection. On the second day of our inspection this had been rectified with the appropriate medication made available.

People told us they received their medicines including pain relief medicines when required and in a timely manner when they requested them. Where people were prescribed as and when required pain relief medicines and were unable to verbally communicate their needs, staff had recorded guidance which described for them potential indicators of pain. Where transdermal pain relief patches were prescribed there was good evidence of body maps in use which indicated where on the body the patch was placed. This provided staff with the information they needed to ensure the weekly application of this medicine was placed on alternate sites of the body as prescribed to prevent harm to people.

The service recruited staff in a way that protected people. A review of staff recruitment files showed us that application forms had been completed which identified any gaps in applicants previous work history. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this setting. References and DBS checks had been confirmed before staff started working at the service.

The provider had systems in place for staff to record cleaning of the environment including the inspection and cleaning of mattresses and bed rail bumpers. The clinical services manager carried out regular checks

of the units to check that infect ion control processes were in place and monitored by staff. We found the environment in the main to be clean and free of offensive odours.

Requires Improvement

Is the service effective?

Our findings

There was a process for induction and training of newly employed staff. Staff recently employed told us their induction prepared them to work at the service with opportunities to work alongside more experienced staff and training opportunities which included recognising and safeguarding people from the risk of abuse, infection control and food safety awareness.

All the staff that we spoke with told us that they felt well supported by both the unit mangers and the general manager who had management oversight for the whole service. Annual appraisals of staff performance had been completed or planned for all staff and provided an opportunity for managers to look at staff's performance and to support them in their continued professional development. Unit managers told us that they had organised supervision sessions with the registered manager approximately every two months and in turn they provided supervision sessions for the staff on each of their units. This was confirmed by staff, who told us they had been provided with regular formal supervision sessions and were able to access informal support and guidance from senior staff if required. The manager had a system in place for monitoring the progress of supervisions and performance reviews and determining when these were due. However, we found that not all nurses had received up to date training with skills to set up, use and monitor a syringe driver. A syringe driver is equipment for delivering pain relief medicines to people at the end of life.

We spent time talking with one of the provider's area trainers who was visiting the service on the second day of our inspection. They told us they were conducting competency assessments on staff to assess their performance and identify any training needs. When we asked about the quality of dementia training available to staff they described to us three levels of dementia training available across the organisation. Level one consisting of approximately one hour was provided during induction training. Level two a one day training event which included equipping staff to understand and develop effective and meaningful communication with people living with advanced dementia. Level three would equip staff, particularly those with leadership oversight to coach other staff. However, we were informed that staff employed within the service including those working in and with oversight of Harlech unit had not completed level three training and there was currently no staff appointed as dementia champions.

At our last inspection we found the provider was not working within the principles of the Mental Capacity Act 2005 (MCA). This meant that people's human rights had not been protected. At this inspection we found that staff had received recent training in understanding their roles and responsibilities with regards to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Care records showed us that people who lacked mental capacity had a best interest assessment carried out so that any decisions made regarding their health and welfare where they lacked capacity had been made in their best interests. Applications for authorisation with regards to the deprivation of liberty safeguards for people where their freedom of movement may be restricted to keep them safe, such as those requiring constant supervision had been referred to the local safeguarding authority.

We observed staff asking for people's consent prior to their undertaking a task. For example, we observed a

member of care staff asking one person with limited verbal communication, "Can I wipe your chin?" The member of care staff took the smile from the person as consent and the person remained relaxed. Daily observation records also reflected staff seeking consent from people before they attempted personal care and incidents of offering choice as to their preference with regards to daily activities.

We previously identified concerns with the administration of medicines administered covertly without having followed the appropriate best interest process in line with the MCA and DoLS. At this inspection we reviewed the care records for people deemed to lack capacity where their medicines had been administered covertly. This is where medicines are administered hidden in food and drink. If a person lacks capacity and is unable to understand the risks to their health, if they do not take their prescribed medicines, and the person is refusing to take their medication, then it should only be administered covertly in exceptional circumstances and in their best interests. Before the medication is administered covertly there must be a best interests assessment and decisions made by those qualified to do so. This would include relevant health professionals and agreement from the person's family members. We noted for the one person we were told had their medicines administered covertly, a 'covert medication assessment' had been carried out which evidenced relevant consent had been obtained by those qualified to do so. For example, the person's relative, their GP and a pharmacist. However, the front of this person's medication administration records where it asked, 'Is the medication administered covertly?' staff had ticked the 'no' box. This meant that conflicting guidance was provided for staff which meant there was more opportunity for errors to occur.

Where people had recently been administered flu jabs we checked to see if they had been consulted and their consent obtained prior to this treatment having been administered. We found people with capacity had signed to consent to this treatment. Where people lacked capacity to consent to this treatment there was documented evidence of relevant consent having been obtained by those with legal responsibility for the health and welfare of the person.

People gave us conflicting comments regarding the quality of the food provided. For example, comments included, "The food is alright, portion size is a bit small, sometimes the food is a bit cold, the fish and chips were cold last week. We get enough choice and on Tuesday and Wednesday we get a cooked breakfast. We get snacks, chocolate, crisps and I have asked for Cuppa soup. I don't go hungry for long. We get enough drinks and snacks but the portions could be bigger for me and hotter", "I have complained that they give me too much to eat. Yesterday we had pancakes with sugar but no lemon but they were nice. It would be nice to have more variety like lamb with mint sauce and roast potatoes. No we don't get asked what we would like to see on the menu but it would be nice to be asked", "Quality of food is half and half" and "Food is always hot but they would heat it up more if you wanted them to. You have a choice of food, they ask you the day before but it's alright to change your mind on the day."

We observed the midday meal on each unit and the tea time meal on day one and the midday meal on day two. On day three we observed the tea time meal and supper on Harlech and Cilgarren.

We found some improvement had been made with systems now in place to ensure the safe management of people's nutrition and hydration needs were being met, in particular for people with swallowing difficulties, those at risk of choking and people at risk of insufficient intake of nutrition and hydration. Care records showed us that people's weights were now regularly monitored. Where people were consistently losing weight referrals had been made for specialist dietetic advice and support. However, we found that following specialist advice care plans were not always updated in a timely manner to reflect the advice given.

The care and treatment of service users did not always meet their needs and reflect their preferences. We noted further work was needed to improve the meal time experience for people living on Harlech unit. Whilst

the midday meal time experience on Cilgarren and Powys was calm and staff supported people according to their needs, on Harlech meal times were observed to be at times chaotic with people supported in an ad hoc manner. There was insufficient staff available at meal times which impacted on people's dining experience. We observed staff trying hard to meet people's needs but having to multi-task. For example, having to get up and down whilst trying to provide one to one support to people who required support to eat their meals to answer the door and assist others.

We observed one person on Powys unit who at 20:30 still had their tea time meal untouched including dried up cheese sandwiches where the bread had become hard and a full, cold cup of tea in front of them which had been untouched since tea time. Staff had recorded in this person's care records that they had eaten a full tea time meal when this was clearly not the case. Staff delivering supper time drinks replaced the cold cup of tea with a hot one and placed two biscuits on top of the dry, inedible sandwiches.

At our last inspection we found it was unclear how the provider supported people to have appropriate access to external healthcare professionals such as GP's and dieticians. At this inspection we found improvement. One person told us, "I see the doctor when I want. I see the chiropodist often and the optician came this week to my room." Another told us, "The doctor comes to see us when we need them. They come here every week. I have new glasses on order. I needed to see the dentist I was in a lot of pain. My [relative] took me."

We saw from a review of care records that people had been referred to the GP who visited weekly and other healthcare professionals when required. For example, referrals had been made when needed to dieticians and speech and language therapists. People had received recent access to a visiting optician and regular opportunities to obtain the services of a chiropodist.

All relatives we spoke with told us they were kept informed of changes in people's healthcare conditions and informed of incidents affecting people's wellbeing. One relative told us, "They always let us know if the doctor has been out to see [relative]. We are kept very well informed of any changes that happen." Another told us, "I am much more settled and worry less about [relative's] care now. The communication has got better than it was before."

We noted a need to improve the adaption, design and decoration of the service on Harlech unit to enhance this unit and improve the environment to meet the needs of people living with dementia and promote their independence. The management team told us there were plans to improve this unit with projects such as building a sweet shop in the lounge and had taken down a wall to improve the layout of the communal dining room and lounge. They had also created a sensory room which we noted did not attract people to use this room and during our visits was not used other than when relatives visited. Further work was needed with access to current research and good practice recommendations in providing a more enabling, dementia friendly environment. For example, improving the signage, changing the bland corridor wall and door colours and providing tactile objects for people to access.

Requires Improvement

Is the service caring?

Our findings

When asked if staff treated them with kindness, dignity and respect people told us, "I love it here, people are nice, food is good and the staff are very good", "I could not ask for anything nicer, we don't have any real complaints here", "I find it very friendly, everybody helpful and whenever you need anything they see to it" and "They care for me very well and they have been careful in their care of me, treat me with respect. I have been pleasantly surprised." Relatives of people living on Harlech unit told us, "The staff work hard and do their best but they do not have time to keep an eye on people who need to be looked after." Another told us, "It is not good that staff cannot keep a close watch of people who constantly go into other people's rooms."

Relatives gave positive feedback as to the caring and respectful interactions they observed from staff. One relative told us, "They have been great. They have just decorated [relative's] room. We chose the colours, a new carpet is coming and they washed the curtains. We would not have left [our relative] here if we were not happy. The carers work extremely hard and they look out for the relatives too. I can go and see the staff in the office if I am not happy. They contact me on my phone and tell me if [relative] is not eating well and of any changes. They are very caring."

We observed some positive interactions between staff and people living in the service, such as a staff comforting people when distressed or speaking to people, positioned at eye level when communicating and supporting them with eating their meals. The quality of interactions varied across the three units observed. Whilst in some areas we observed staff sitting and chatting with people, with lots of laughter and friendly interactions other areas staff interactions were more related to the completion of a task such as supporting people with their personal care or serving meals and drinks.

Staff were observed to be respectful in their interactions with people. For example, when offering care, respecting people's wishes and refusals and when supporting them with their personal care.

We observed the lunch time meal on the first two days of our inspection and saw some good examples of staff supporting people in a kind, compassionate and un rushed manner. For example, one person was supported to eat a pureed meal whilst being supported at a slow place. When only a few mouthfuls were eaten. The staff member attempted to engage the person in conversation without any response. The member of care staff asked if they wanted any more to eat, when the person shook their head to decline the staff member asked again to confirm their wishes. They then recorded the correct amount in daily records.

Care plans contained limited information as to people's preferred wishes and preferences about how they would like to live their day and support that should be provided to enable them to do this. Care records remained mainly task focused lacking detailed information as to how people would prefer to be supported and support to individuals through social stimulation linked to their level of dementia. There were no clear routines which would demonstrate people's involvement in planning for their night time needs or how their medical conditions such as macular degeneration impacted their daily living.

We observed a visiting professional discussing the needs of a person openly with a nurse which could be

overheard by others. We noted that there was no attempt made by the nurse to divert this conversation to a more private area where confidentiality could be protected and respected.

We found on Harlech unit a lack of recorded life histories which is recognised as good practice. A life history book is a book compiled to capture memories and stories about a person's life. Making a life history book can be an enjoyable and empowering activity for a person with dementia which may enable greater interaction and open up communication between the person living with dementia and their care staff, family and friends. A life history book can be referred to by professionals to learn more about the person they are providing care for.
We found inconsistencies in the quality of records which would guide staff as to people's needs, wishes and preferences regarding their end of life care. We spoke with a visiting health care professional from the hospice at home team. They told us they had been supporting the service doing some teaching and training of staff on end of life care. They also told us they had supported the service with the provision of new care planning document known as 'my care, my wishes' to enable staff to ascertain and record people's wishes as to their care at the end of life.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found care plans to be generic and not person centred, often containing the same information for each person. There was limited information available which would describe people's likes and dislikes, preferences and choices. Whilst we found some improvement at this inspection further work was required to ensure that care plans reflected the current needs of people and reflected their choices and preferences as to how they chose to spend their days including provision to support people to maintain their hobbies and interests as much as they are able.

The care and treatment of service users did not always meet their needs and reflect their preferences. We found inconsistencies in relation to the information recorded in some people's care plans. This was a particular concern given the number of agency staff employed where the front sheet to the care plan known as 'My day, My life, My portrait' provided these staff and others with a summary of a person's health, safety, care and support needs. Where staff had updated some care records when needs had changed, the summary care plan had not always been updated and contained conflicting information. Which meant that agency staff and others did not always have the most current information available to them. This had the potential to put people at risk of not having their health, welfare and safety care needs met.

We found a lack information providing guidance for staff which would indicate that the individual needs of people with regards to their continence needs had been adequately assessed. Care plans lacked information as to prescribed continence aids. Continence aids including protective pads should be assessed for the individual according to the size and type that they require. Having aids that are too big can cause chaffing of skin and if too small or not absorbent enough, could allow leakage and skin could become excoriated if left in contact too long. For two people prescribed, a particular size of continence aid was described within their care plan. However, in their room we found the aids provided were not according to their assessed needs. This led us to determine they may have been given another person's prescribed aids.

For one person with a long term indwelling catheter the care plan recorded that the size of catheter to be used and that it should be changed three monthly. However, there was no guidance for nursing staff as to how often the leg bags should be changed. Another person's records contained contradictory information as to the size of catheter. Where records stated catheter leg bags required changing every three days, there is was no information given in the care plan as to the reason for this. The guidelines from the provider of the leg bags in use advised that leg bags are changed every five to seven days and only earlier if damaged. This is to lessen the risk of cross infection and therefore unnecessary changes raised the risk of cross infection.

We noted for a number of people there was limited information as to their wishes and preferences in relation to their future decisions including their wishes at the end of life. We found one person's care records with a do not attempt resuscitation order in place (DNAR). The information on the order was crossed out and staff had written 'Void now wishes to be brought back to life'. However, there was also another DNAR document in place for a later date. We noted that neither form had any evidence that the person's wishes had been consulted as this person had full capacity to make their views known. We found in another part of their care plan a record stating 'do not resuscitate' but the 'not' had been crossed out. This meant it was not

clear what the exact wishes of this person were and their consent obtained.

We found there to be inconsistent information available across the different units to guide staff with regards to wound care management. Whilst some care plans contained clear concise information others were lacking in detail to guide staff in the steps they should take to mitigate the risks to people. For example, we reviewed the care of a person receiving their nutrition and medicines via a percutaneous endoscopic gastrostomy (PEG) tube in place. A body map was in place and recorded 'peg site remains quite red' following a recent infection. In the professional visit record of the care plan it recorded a recent visit from a nurse specialist who had written in the care plan, instructions for staff to ensure they regularly rotated the tube and ensure it was in its correct position. We asked the nurse on duty if there was a wound care plan for the peg site. They said "no." We also asked how often the peg site was being cleaned and a dressing renewed. They told us, "I'm not really sure, every two or three days I think." We asked how the date as to when a dressing change was required was determined and how this was communicated to staff. The nurse told us they did not know. We determined this to be poor practice, as there should be a plan of care for the PEG site, such as daily cleaning and tube rotation to prevent adherence of the tube to the sides of the tract into the stomach. The PEG site should be classed as a wound and identified as an area of potential risk with a specialist nurse being asked for advice and to regularly review the site. The result from a GP having previously assessed and treated infection at the PEG site had still not generated a management care plan for the area. This put this person at risk of further infection.

We found for another person the skin care section of their care plan in relation to the care of their acquired pressure ulcer, 'dressing to be changed at least every three days. Photo and reassess weekly '. We found seven to 12 days gaps recorded. This could lead to a higher risk of cross infection if the dressing becomes sodden and leaks onto the surrounding skin. This could also potentially lead to skin irritation from exposure to the exudates as dressings have an optimum amount they can absorb.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of social isolation. There were a high number of people who stayed in bed. It was not always clear within their care plans as to why this was the case. Whilst we observed staff on Cilgarren and Powys to have some to sit with people and support them with puzzles and nail manicures, on Harlech a designated unit for people living with advanced dementia, staff did not always have time to sit and talk with people for any meaningful period of time. We found the number of hours provided for staff specifically employed to support people with social activities was limited with very little one to one activities for people confined to their bed or where people spent the majority of their time in their room.

The provider's website claimed; 'We provide regular opportunities for people to visit local places of interest'. We found that there was no programme of regular trips to local areas organised apart from the one off occasional outing. A trip was in the process of being organised for the following week but this was limited to a small proportion of the people compared to the number living at the service and staff made the decision as to who would be allocated to attend. Planned group activities were limited to weekdays only. We observed people left for long periods without meaningful occupation particularly on Harlech unit where this provision may have averted some of the behaviours we observed where people appeared to be bored and looking for the company of others. The manager told us they were in the process of recruiting more staff to improve the allocation of staff which would include planned activities at the weekends.

People had access to clear information about how to raise concerns and complaints. There was a written

procedure available throughout the service on notice boards. There was a suggestion box in the reception area, available to enable people to log any suggestions and concerns easily and anonymously if they chose.

There was a complaints process in place. Not all of the people we spoke with were aware of this. However, we found a clear audit trail for complaints that had been received, with actions taken in response and with outcomes evidenced. The provider did not have any effective observational tool currently in use which would support the experiences of the people using the service, particularly for those living with dementia, with limited verbal communication and where their attendance at residents meetings would not prove to be meaningful.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 we identified significant shortfalls in the care provided across all three units. This was linked to a lack of effective management including clinical oversight of the service. Quality and safety monitoring processes were ineffective and did not identify the shortfalls which put people's health, safety and welfare at risk. We took urgent action in response to our findings to stop the provider admitting anyone new to the service by amending their conditions of registration.

At this inspection we found there had been a change in the management structure of the service and some improvements had been made. The registered manager had left and a new manager appointed in August 2016. There is a requirement for this service to have a manager registered with the Care Quality Commission (CQC). The manager told us they had completed their application to register but their application was currently with Bupa's legal team for review before submission to CQC.

Relatives spoke of the improvements since the last inspection in relation to; more visible management, improved response to complaints, cleanliness of the environment, staff morale and the manager's prompt responses to concerns and complaints.. Comments included; "There have been lots of staff changes but for the better. The management is delivering on what they are saying", "decoration and the environment have definitely improved" and "Things are settling, it is a much better place now."

Staff told us, "The morale has improved. We are much better supported and the manager is often on the units. If we tell her anything we are concerned about she gets it sorted. She always asks you how you are and appears genuinely interested." Another said, "The new manager does a good job, definitely approachable. We just need more staff and not agency staff. If we had ore staff we could spend more time with people. This is the resident's home, now it's up to us to keep everyone comfortable."

Staff told us they had regular access to staff meetings and supervisions where they could air their views. They told us these meetings were informative and helpful at improving communication across the units.

Each unit had a designated unit manager responsible for the day to day management of their unit and a deputy manager. However, we noted that the unit manager had only six hours per week where they were not expected to be allocated to the rota to allow them time to accomplish staff supervisions, manage the staffing rota, update care plans and complete audits of their units. Deputy unit managers did not have any supernumerary hours allocated to them even when the unit manager may be on leave. Unit managers were nurses who told us, and rotas confirmed, that they often lost their six hours non-clinical time to manage the staffing rota taking action to cover vacant shifts arising from nursing staff shortages. We remained concerned, as identified at the previous inspection as to the ongoing high and consistent use of agency nursing staff. Staff told us this impacted on the consistency of care and on occasions resulted in a lack of effective communication regarding people's care needs from one shift to another and to the quality of recording of care provided. We noted from observing handover's and discussions with staff that agency staff did not always know people very well. We noted that handover communication record sheets did not always include a concise, up to date handover of information in relation to changes in people's care and concerns

in relation to people's care needs. For example, we found incorrect, conflicting and inconsistent information passed from one shift to another regarding people's inadequate nutritional intake and medicines which had not been administered. We therefore remained concerned that the current lack of permanent nursing staff meant that the health, welfare and safety needs of people may not be fully met.

Staff and people's relative's told us the manager operated an open door policy and were confident that any issues they raised would be dealt with promptly. Staff told us they could make positive suggestions and people could speak up if they had concerns or ideas. We saw that both staff and resident meetings were now held on a regular basis so that people were kept informed of any changes to work practices or anything which might affect the day to day management of the service.

Staff told us and the manager confirmed there had been a high turnover of staff since the last inspection. All staff we spoke with said that there had been a positive change in the culture of the service which they said was more focused on the needs of people who used the service. They told us this was due to changes in staff who worked at the service and the new manager listening to staff and taking action where needed. For example, where the need for additional resources had been identified and taking action when staff had identified risks.

However, there was a further need for development of the service. We identified continued shortfalls in relation to people having access to sufficient numbers of, suitably qualified staff at all times to meet their needs and including the need for improved provision of training, development and deployment of staff to meet the needs of people living with dementia. We continued to be concerned regarding the lack of supernumerary hours allocated to unit managers assigned to each unit who were responsible for the overall management of staff designated to those units and for monitoring the quality and safety including the clinical care needs of people. There was little time for these managers to plan and develop their service and this was particularly noticeable in relation to Harlech the unit designated for people living with dementia where improvement was noted.

Staff told us that due to the shortage of nurses the unit manager's regularly gave up their supernumerary hours which would otherwise have been used to provide supervision support to staff, manage the staff rota to cover vacant shifts and carry out quality and clinical safety audits. We determined that the majority of shortfalls we identified at this inspection linked to this as the main issue.

We saw that there were some improvements with systems in place for continuous quality and safety monitoring of the service. The provider had employed a clinical services manager with clinical oversight of the service. There were improved clinical audits which included the monitoring of hospital admissions and discharges, safeguarding concerns, falls, wound and weight monitoring and the audit and management of medicines errors. Other quality audits included a review of care plans and safety of the premises. We saw documentary evidence that these took place at regular intervals and any actions identified were addressed with timescales for actions to be completed. However, we found that not all the shortfalls we found at this inspection had been identified.

The manager told us they carried out regular monitoring of the units completing a clinical walk around the service daily which was documented and included a record of their findings and responses to shortfalls identified. Daily, lead staff from each department came together to meet. These meetings were known as 'Take 10' meetings and were documented with what was discussed and actions taken in response to any concerns identified.

We found the manager was receptive to our feedback and responded where they were able to, when they

had access to available resources. However, we remained concerned at the length of time it took for the provider to make available to their manager's, resources to enable them to respond in a timely manner to identified risks to people's welfare and safety. For example, where the manager and staff had identified risks of inadequate numbers of hoist slings available to individuals according to their assessed needs, to mitigate the identified risks of harm.

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 care and treatment of service users did not always meet their needs and reflect their preferences.

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 The provider did not always assess and protect people against the risks by way of doing all that is practicable to mitigate any such risks.

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 Sufficient umbers of quailed and skilled staff were not always deployed and available in order to meet people's needs.