Delphine Homecare Limited

Annabel House Care Centre

Inspection report

57 Bristol Road Lower
Weston-super-Mare
Somerset
BS23 2PX
Tel: 01934 416648
Website: www.annabelhouse.co.uk

Date of inspection visit: 11 and 13 January 2016
Date of publication: 13/04/2016

Ratings

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

Overall summary

Annabel House Care Centre provides accommodation for people who require nursing and personal care for up to 32 people. On the day of inspection there were 19 people living at the home. Most residents were living with dementia so were unable to express their views regarding the support they receive. The accommodation is arranged in one building over two floors. The main offices are located in the basement of the home and the nurses' office is located between two living spaces.

At the last inspection, we found breaches in the home because staff were not receiving supervision in line with the provider's policy and there was a shortfall in training. Staff had not read care plans and were not delivering care in line with what was in the plans. We found the home was not well led because there were gaps in the audit systems and they had not identified all the shortfalls we found. Since the last inspection, the provider and registered manager have been sharing changes they had made in the home. Although there had been some improvements, we found there were still concerns.

This inspection was unannounced and took place on the 11 and 13 January 2016

Summary of findings

The home had been working towards the Butterfly Project in conjunction with Dementia Care Matters. This is an approach of working with people with dementia where you accept the world as they see it. Staff did not wear uniforms, they had name badges and positive interactions with people are encouraged. There are four lounges set up for different stages of dementia.

A clinical lead nurse supported the registered manager. A registered manager is a person who has been 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 told us they felt safe but there were risks to their safety around pressure care, risk assessments, moving and handling and medicine management. Where staff had identified pressure related wounds, plans had not been put in place to manage them. Medication procedures were not always following best practice and this was putting people at risk. People who required support were not always transferred between chairs following best practice and their risk assessments were not detailed enough to tell staff what to do.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if people did not want what was on the menu to ensure their preferences were met. However, there were times people's weight was not being monitored and people were not receiving the correct food supplements.

Staff were receiving regular supervisions in line with the provider's policies and there had been some improvements with the training staff received. However, the staff did not get all the training they needed to carry out their duties.

The staff were aware of their responsibility to protect people from avoidable harm or abuse and most staff had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and they knew whom to contact externally. The recruitment process did not always follow good practice, which meant people were put at risk from staff who had not had the correct checks from the provider.

The provider and senior management had an understanding about people who lacked capacity to make decisions for themselves. There had been some improvements into recording decisions made in a person's best interest. However, care plans had not made the consultation process clear when people lacked capacity or had decision specific assessments. When they had decided to prevent people leaving the home for their safety the correct processes had been followed. But they had not always completed the correct process when bed rails were put in place to keep people safe. As a result, there were breaches of people's human rights.

The registered manager and provider had followed their legal obligations to notify CQC of other incidents. The registered manager and provider had regular meetings including one to review audits completed in the home. The audits were up to date and on occasions had been identifying shortfalls and recorded improvements. However, the systems were not identifying all shortfalls in the home or where some had been identified no actions had been taken. When we were told actions had been put in place to reduce the risks in relation to safeguarding these had not been completed.

The nurses and activities coordinator were in the process of updating and rewriting all the care plans. Where care plans had been updated there was evidence of people or relatives being involved. However, some people's care plans were not complete or were not person specific. Not all the care plans had a person centred approach to them.This meant people were not central to their care and decisions they made for themselves or that were made for them. Staff had some knowledge about the care plans, but explained they had not had time to read them all.

Staff supported people to see a range of health and social care professionals to help with their care, but sometimes referrals were not been made in a timely manner. Staff supported and respected people's choices and they knew how important this was.

People and their relatives thought the staff were kind and caring; we observed mainly positive interactions, but some were to fulfil tasks. The privacy and dignity of people was respected most of the time and people were encouraged to make choices throughout their day.

Summary of findings

People knew how to complain and there were good systems in place to manage the complaints. The registered manager and provider demonstrated a good understanding of how to respond to complaints.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering the action we are taking.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were concerns around people's pressure care and medicine management did not always follow best practice.

Risk assessments did not always contain enough information and moving and handling had not always followed best practice.

Risks of abuse to people were not minimised because the recruitment procedure for new staff did not always follow best practice.

Safeguarding action plans were not always followed to reduce the risks to people.

Staff were able to tell us how to keep people safe and who to tell if they had concerns about people's safety.

Is the service effective?

Inadequate

The service was not effective.

Staff demonstrated some understanding about making best interest decisions on behalf of someone who did not have capacity, but it was not always put into practice or documented correctly.

People were at risk of their human rights being breached because the correct procedures were not being followed.

Some staff had training to meet the needs of people they supported; but there were still gaps in people's training especially around managing challenging behaviour.

Most people had their nutritional needs met but there were occasions when people needed support or supplements. There was access to other health and social care professionals but referrals were not always made in a timely manner.

Is the service caring?

Requires improvement

This service was not always caring.

People told us that they were well looked after and we saw most of the time the staff were caring. However, there were times when people needed support and staff did not identify it.

People were involved in making some choices about their care.

Most people's privacy and dignity was respected.

Is the service responsive?

Inadequate

The service was not responsive

Summary of findings

Some people had care plans that were not always completed or personal to their needs and wishes. Some people had no written care plan.

Not all staff had read the care plans and care was not always delivered in line with them. Sometimes, there was not enough detail in care plans to make sure staff knew how to keep people safe and meet their needs.

People and relatives knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Inadequate

The service was not well-led.

The home had up to date audits, but they had not identified all shortfalls and identified actions had not always been completed.

The provider had regular meetings with the manager, which included checking the audits of the home.

The provider and registered manager had a reactive approach to running the home.

The home had a clear vision, which followed the Butterfly Approach and people said it felt homely. However, when staff were not following the approach little had been done to change this

Annabel House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 13 January 2016 and was unannounced. Three inspectors and an expert-by-experience carried it out. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for people with dementia. This was a full comprehensive inspection and followed up on concerns from our last inspection in July 2015. We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Instead, we viewed this information during the inspection.

We spoke with five people that lived at the home. We spoke with the registered manager and eight staff members, including two registered nurses. We spoke with two visitors. We also spoke with two relatives and nine health and social care professionals on the telephone.

We looked at 16 people's care records and observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at six staff files, the provider's action plan, previous inspection reports, rotas, quality assurance audits, the home's training records and supervision records, minutes from meetings and a selection of the provider's policies.

Inadequate

Is the service safe?

Our findings

Even though some people said, the home was safe there were areas that placed people at risk. For example, pressure care, risk assessments, people's transfers between wheelchairs and seats, and systems in place to prevent infections from spreading.

Risks to people using the service were not being managed effectively so people were not always kept safe. Although care plans contained risk assessments for aspects of their support such as how to safely transfer people and falls, some were incomplete. Completed risk assessments did not contain the level of detail required for staff to keep the person safe. For example, one person's plan stated they were prone to falls and had fallen three times in 11 days. Their plan informed staff the person was "Unsteady on feet" and they should "Keep the environment free from risk and wear suitable footwear". However, there was no further detail on how staff should keep the person safe and how they could minimise the risk of further falls. Notes show a meeting between the relative, the registered manager and clinical lead was held and alternative methods to protect the person had been dismissed. The outcome agreed by all present said, "Carry on and accept the risk of falls". Since the inspection the provider has informed us that the registered manager and clinical lead said that other options to reduce or remove risks were limited and would have a detrimental effect on the person's wellbeing and to "carry on and accept the risk of falls" was the least restrictive option. This decision had not been discussed with other professionals, such as the falls team, to ensure the person's health and safety has been fuly considered with the best interest decision.

Another person's plan said "Able to walk independently and will probably fall. Staff to assist with first aid and provide medical assistance as necessary". The care plan lacked details to inform staff how to prevent the person falling. For example, the plan informed staff to "Ensure environment is safe and free from hazards". There was no further information about what this meant or how staff should do this. As a result, staff would not have the information to reduce the likelihood of falls for this person. This meant staff were not shown how to reduce the risks to people and keep them safe.

Moving and handling risk assessments in care plans did not contain enough information for care staff to know how to keep people safe. Moving and handling refers to how much support, if any, people need to move from one place to another. On one occasion, a person was being transferred between two chairs using a specialist piece of equipment. During this transfer, they were left hanging in the air unnecessarily because staff had not moved the armchair nearer to the person before they started the transfer to reduce the amount of time the person was in the air. Best practice is the person should be in the air for the minimum about of time. This placed the person at avoidable risk and did not consider their welfare. When a staff member was asked how they knew the method to help this person, they said, "We follow risk assessments in the persons care plan". We asked if either member of staff supporting the person had read the person's care plan but they did not confirm they had.

A second person was being supported by two staff to transfer between a wheelchair to an armchair with no equipment. The two staff put their arms behind the persons back and as the person stood, they fell back into the wheelchair; this pulled the staff down with them. This could have hurt the person and the members of staff. The Clinical Lead said assisting people by linking arms behind their back is acceptable because some people do not like wearing special belts to help support them. Linking arms can be appropriate if the person is able to safely support their own weight. However, in the person's moving and handling risk assessment, it stated the person's standing was variable; therefore, it required ongoing assessment and if required, the use of a mechanical aid. There was no information about the different options staff could use or when they should be used. By not having enough information in this person's risk assessment the staff were in danger of hurting the person and themselves. Since the inspection a health and social care professional has assessed the person and they now use standing aids to help with transfers.

The provider's Moving and Handling policy stated "The home's policy will, so far as is reasonable practicable provide the information, instruction, training and supervision required to ensure the health and safety at work of employees and others." As well as the practice which was observed that put people at risk, two further people did not have a care plan with information about how staff should support them to be transferred. The lack of care plans and detailed information for some people meant the provider was not following their own policy. We

had a discussion with the registered manager and a registered manager from the provider's other home who both acknowledged there needs to be more detail in the risk assessments for moving and handling people.

People were at risk of developing pressure related wounds because special air mattresses were not set correctly. There were a range of air mattresses in the home; they had different settings such as being set to the weight of the person or reading low, medium and firm. However, no individual instructions or guidance was in place for staff. A person who had a significant wound had their mattress set at firm. An agency nurse could not say what setting the mattress should be on and there was no guidance in the person's care plan. Another mattress required the setting to be made based on the person's weight. However, this was set incorrectly as their care plan recorded their weight to be 73.1kg and the mattress had been set to 90kg. The provider said they were unable to say why two mattresses had been incorrectly set but said staff could have knocked them. On the first day of inspection, several other mattresses were found incorrectly set for people. The clinical lead was aware mattresses should be inflated to people's weights and told us they take the weights folder to bedrooms to check mattresses were inflated correctly. When the clinical lead was not on duty, there were no records of mattress checks and the clinical lead confirmed this.

There were people in the home the provider identified as being at high risk of pressure wounds. On arriving at the home, the local authority safeguarding team were sent a report by the registered manager for one person as they had a known wound. However, after over three weeks this person had no wound care plan in place for staff to refer to when treating the pressure sore. An agency nurse who was the lead nurse on shift was not aware of how serious the wound was. No photographs had been included in the person's care plan to demonstrate how effective treatment had been. The clinical lead told us the wound should be checked and dressed daily. They said there were photographs on their camera. The "Wound Check" folder showed the wound had not been redressed by staff that frequently; on five separate days, the wound dressings were not changed. The provider's pressure relief policy stated staff should "Adopt and implement the prescribed plan of care"; this was not possible because there was no plan of care. Therefore, this person was not safe and their care was not in line with the provider's own policy. Following the inspection, the person has a wound care plan put in place.

People's medicines were not always managed safely. The provider's procedure for the disposal of unwanted medicines stated, "The medicines must be taken and placed in a secure cupboard or container". Medicines for disposal had been placed into a container, which was kept under a desk. The desk was part of a thoroughfare for people and staff. There was a risk people would be able to access these medicines because they were not stored in a locked cupboard and the container was not secure. The medicines fridge was in the same thoroughfare and was unlocked. Although, at the time of the inspection, only creams and eye drops were being stored in the fridge and there was a risk people could access them.

Medication stock checks took place, but when discrepancies were noted, they had not been reported as incidents. There was no documentation in place to show how the discrepancies had been investigated, resolved or how lessons had been learnt. For example, stock balance inaccuracies were noted on one day. There was no incident report or investigation to find out what had happened. It was unclear because of poor reporting and follow-up if the cause of the incorrect stock balance had been resolved or not. This meant people were at risk of medicines not being correctly administered, as stock errors had not always been investigated.

Medicine administration records (MAR) were completed in full and there were no gaps in the recording of medicine people had been given as recorded in the current medicine file. Photographs were in place at the front of the MAR charts for the majority of people using the service; however, these were missing for four people and the ones in place were not dated. This meant there was a risk staff could administer medicines to the wrong people as photos were missing and people's appearances may have changed. The risk was increased because the service was using agency staff.

We found the home was not following best practice in infection control. Infection control means the protection of those who might be vulnerable to acquiring an infection. The basic principle of infection prevention and control is hygiene. Members of staff were able to tell us about the principles of infection control. One member of staff was

able to list the different types of personal protective equipment such as aprons and gloves. Another staff member explained you should not leave the room with aprons or gloves on. However, we saw examples where staff were not keeping the risk of infection to a minimum. In one bedroom, we found a commode lid on the floor and a commode pot next to a plastic bowl used by people for their morning wash. A commode is equipment that allows people with poor mobility have personal care opportunities without the need of a bathroom. Staff were not ensuring clinical waste was being placed in the correct container with a lid to prevent infections spreading. For example, in a bedroom, there were used gloves and incontinence products in an unmarked bag on the floor. A member of staff explained they do not like leaving the person in their bedroom on their own; they said they put it straight in the clinical waste bin after taking the person downstairs. On another occasion there were used gloves left on a fire hydrant. We saw a member of staff coming out of a bedroom to access a communal cupboard with one protective glove on and the other one off; protective gloves should be removed when leaving a room to reduce the chance of spreading infection. The cleaner was not using a separate mop or wearing a disposable apron and gloves when cleaning the bedrooms. When we identified these issues to the cleaner, they rectified the problem.

There was a sign at the entrance to the home stating the home was unable to accept visitors due to an outbreak of illness so the home needed to control the number of people in contact with those in its care. A person arrived for respite and their family was invited into the home as visitors. The agency nurse in charge was not sure if the home was clear of infection and said they thought it should be open to visitors the next day. The registered manager confirmed they were lifting the visitor restriction the next day. By allowing visitors in before the restriction had lifted there was a risk that the infection could be spread further. Following the inspection the provider told us it would have been disproportionate to prohibit a relative from settling their loved one into a new and strange place when they were living with a severe dementia as the visiting restrictions were being lifted the next day. By allowing visitors in before the restriction had lifted there was a risk that the infection could be spread further. Following the inspection the provider told us it would have been disproportionate to prohibit a relative from settling their loved one into a new and strange place when they were living with a severe dementia.

On the floor in one bedroom, which had a “barrier nurse” sign on the door, there was used pyjamas, unmarked bags containing used incontinence products and used tissues. Barrier nursing refers to a method of delivering care to someone in isolation to prevent the spread of infection. There was no antiseptic hand gel in this bedroom just ordinary soap on the en-suite basin. Another bedroom with a “barrier nursing” sign had a toilet that was out of order; this meant the person may have to leave the room and risk spreading the infection. Access to the hand basin was made difficult by all the bags of incontinent products on the floor. By not having the necessary hand wash, access to hand washing facilities and the out of use toilet the home were preventing effective barrier nursing from occurring. This increased the risk to people and staff living at the home of being exposed to infection.

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

One person said, “I feel really safe here. Never felt safer.” A relative said they were “Happy with what they had seen” when asked if they had witnessed anything unsafe. Staff understood their responsibilities for keeping people safe from harm. They were able to tell us the safeguarding procedure they would follow to protect people and felt able to whistleblow if required. Whistleblowing is the process of a member of staff alerting a person in authority or the public to wrongdoing within an organisation. One staff member said, “I would report things and take it straight to the manager.” Another member of staff said, “If I was not happy with how safeguarding was dealt with I would take steps to do something about it.” Staff were aware that they could share concerns outside their service.

However, we followed up the outcome of a safeguarding that had occurred in the home where concerns had been raised to the local authority. In November 2015, to reduce the risks the registered manager had reported a number of systems had been put in place to prevent harm to service users and staff. The registered manager had confirmed with a member of the local authority safeguarding team that there should be a slide sheet on the wardrobe in bedrooms; we found seven bedrooms out of 11 that did not have a slide sheet.”Slide sheets are a piece of equipment

that staff use to help people move in their beds and chairs when they have limited mobility. When we asked a member of staff whether a bedroom needed a slide sheet, they confirmed it should have one. They continued to explain everyone should have a slide sheet in their bedroom. The provider was therefore not following the agreed plan with the Local Authority to reduce risks to people.

Another action agreed by the registered manager with the local authority was reviewing protocols around evening medicine; this was to prevent a person becoming too sleepy to be assisted to move in line with their care plan. The actions were necessary to prevent injury to members of staff or the person. There was no record for this person to show the change in medicine administration had been reviewed. The registered manager confirmed they had not completed this action.

A final agreed action following the safeguarding was for the management to complete weekly night checks following a rota; the incident occurred over a night shift. Management had completed two night visits since November 2015 to date and said there was nothing to report so there were no records. There were also no rotas to show who should be completing these checks. This meant people were still at risk from the concerns that were raised in the safeguarding because agreed actions to reduce the risk had not happened.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have in place an effective recruitment procedure to ensure people of the right character were employed. Not all staff had the undergone specific checks such as obtaining references from previous employment. When they recruited staff, two staff members only had had one reference in place. One staff member had not signed a section of their application form to say they had not been in trouble with the police; the provider had not completed a Disclosure and Barring Service (DBS) check either. A DBS check is a way that providers can check whether potential staff have any criminal record in order to protect the people they are in regular contact with or providing their care. Another member of staff had not completed a DBS. The administrator said the staff were not part of the support staff and they were not providing direct care; therefore, the provider did not feel they were required to have a DBS check. We saw this staff member assist a person with a drink and on another occasion was linking arms and supporting a different person to walk across the room. Following the inspection, the registered manager told us they agreed this member of staff had acted beyond their remit. One staff member had no official confirmation of their home address. This meant the provider was unable to know where the staff member lived. This meant people were not being kept safe from staff who have regular contact with them.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's relative told us they wondered why there were so many staff at times when asked if there were enough staff. Another relative said, "There is usually quite a few staff". Staff explained there were sufficient staff on duty if everyone turned up. When we asked one staff member if there was enough staff they said, "Yes, we have enough staff". Another said, "Most days we are okay and if we are short we get agency staff in". We spoke to the registered manager who explained they look at the needs of the people to identify staffing levels. The required staff levels are identified by talking to people, initial assessments and observations. They had identified people needed more help in the morning so increased the staff level. Rotas confirmed when shortfalls were present the use of agency staff or current staff members helped to fill them. Our observations showed there were sufficient numbers of staff on duty to meet people's care and support needs.

Inadequate

Is the service effective?

Our findings

At the previous inspection, there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all staff were receiving supervision in line with the provider's policy and there were shortfalls in staff training. At the beginning of this inspection, the provider told us they have been working hard on the training. They told us they now have all staff trained and there is a new company providing a majority of the training online that they can monitor. The provider shared with us their plans about competency checks to ensure the training was effective.

There had been improvements in training and supervision since the last inspection. Supervisions are a way for the provider identify if staff had received appropriate support, training and professional development to enable them to carry out their duties. All staff had received supervisions within the last three months in line with the provider's policy. This meant the provider was supporting their staff through more formal arrangements. Staff told us they received regular training, which included moving and handling, fire training and dementia care. The home shared a training officer with another home. The training officer explained the new system of training would ensure all staff were up to date in their provider set core skills training by the end of January 2016. Staff said their online training gave them sufficient information to do their job. For example, they could explain what they had to do to ensure people's skin remained in good condition and they knew how to use moving and handling equipment. All staff said they had up to date moving and handling training and this was confirmed by the training records.

However, a third of staff still needed to complete training in nutrition and hydration, safeguarding awareness and mental capacity training. People were at risk of being supported by people who did not understand about their needs and how to keep them safe. Staff had mixed opinions about the induction they had received. One member of staff said they had shadowed other staff for three days and completed their induction training. Two members of staff told us they had "on the job" training for their induction. During this inspection, we found one member of staff inappropriately lifting something that meant they were at risk of hurting themselves.

At the last inspection, we recommended the provider should review staff training around restraint. Since the inspection, the provider has sent six staff on training for challenging behaviour, this included information about restraint and how to safely break away from a person holding you. We asked staff how they managed the behaviours that challenged. One response lacked understanding of how they would safely deal with the behaviour. Another staff member said, "The nurses had the training and those that attended showed us how to do it". The registered manager and clinical lead confirmed the staff who had attended the training were expected to disseminate the information to other staff; it was unclear if this information had been shared. The course the staff had attended was not a train the trainer course, which means the level of training received was a starting point and introduction; the staff were not equipped with enough knowledge to make them trainers. The registered manager acknowledged this was an ongoing concern that staff found particularly difficult and it had been part of the staff surveys actions in May 2015. The impact of the lack of training could be seen in the home. For example, we saw a care plan where someone was documented as having challenging behaviour but there was no detail around what staff should do in those situations. This meant staff who had not received the training were given no guidance of what to do in these situations.

Another person's plan had documented specific behaviour that would challenge. There was no information on why the person might display these behaviours, what triggers them or how to diffuse the situation. The providers Handling Challenging Behaviour policy stated, "Staff will undergo specialist training to ensure awareness of the types, causes and effects of challenging behaviour". However, not all staff had received the training and care plans did not provide enough detail to inform staff how to prevent or manage these situations. This meant staff were not being given appropriate training to enable them to carry out their duties.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people

make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. At the last inspection, we recommended the provider seek advice and guidance from a reputable source about the application of the MCA Code of Practice. Since the last inspection, there had been some improvements because staff were more aware. One staff member said, "Over time people with dementia lose their ability to make decisions". They continued to explain once people are unable to make decisions any more the MCA must be followed. Another said "We assess how much capacity they have and make the choices for them which is best for them not us". However, relatives we spoke to said they had not been involved in best interest decisions. Best interest decisions are a way of multi-agency teams, the provider and loved ones ensuring they are making a decision following the principles of the MCA on behalf of the person who lacks capacity. One relative said, "I am not sure I have been involved in any sort of best interest". The relatives explained they were asked things by the registered manager but had not been to meetings and were unaware of the purpose. Records did not consistently show evidence of these discussions for every decision. Following the inspection, the registered manager explained they do ask for relatives' input in regard to best interests decisions for things like covert medication, bed rails and how to manage the risk of falls. The registered manager continued to say although this is explained to relatives, they may not fully grasp the full process of how the home goes about making best interests decisions.

MCA assessments were not being consistently completed for all decisions that required them. Although there was evidence of best interest decision meetings in relation to the administration of covert medicines, there was not best interest decision for other parts of people's care. For example, when people had no medical condition requiring monthly blood sugar monitoring there were records showing people had this during 2015 on a monthly basis. We were told this had stopped happening by the clinical lead because it was not appropriate; on the first day of inspection, we saw the agency nurse prick the finger of one person to check their blood sugar. The person was not diabetic and there was no documentation in their care plan as to why this was required. There was no record in people's care plans of consent being sought, MCA assessments or best interest decisions prior to undertaking this procedure. We spoke to the registered manager about this and they were not aware the practice was occurring. They explained the procedure should only be done when there was a specific need and they thought this was the practise in the home. Therefore, people had received medical tests that were not required and had been conducted without checking a person's consent; if required, no best interest decisions had been completed.

We looked at the record of a person who had a mental capacity assessment for the use of covert medicine. Covert medicine means they are hidden in food or drink to help the person take necessary medication that is in their best interest. The best interest record had no information the next of kin had been contacted or involved in the decision. The same person had another mental capacity assessment that appeared to cover many other areas so not decision specific. This meant the provider had not adhered to the MCA code of practice; they had not followed the two-stage test for each decision outlined in the code of practice. There were no best interest decisions other than for covert medicine despite the assessment identifying the person did not have capacity. There was a risk that this person's human rights would be breached because the principles of the MCA had not been followed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met.

Where one person had capacity, they were able to leave the premises by asking staff to let them out of the home. This meant they were following the DoLS principles for this person. Further evidence was seen when DoLS applications had been completed which covered people being unsafe if they left the premises and had constant supervision. However, staff did not always demonstrate an understanding of lawful and unlawful restraint. For example, when we asked about best interest decision made in relation to the use of bed rails staff did not recognise that bedrails constituted a restraint and were

depriving people of their human rights. One person had bed rails on their bed and no risk assessment, MCA assessment, best interest decision or DoLS application had been made for this. We spoke to the registered manager who agreed that no DoLS application had been completed for the bed rails. This meant the person was being restrained with bed rails so their human rights had been breached.

This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care plan documented "Can take an hour to eat the meal" and they had set ways of eating. The staff were aware of the person's preference except for the agency nurse who approached the person and offered to heat the meal up for them. The person subsequently became angry and agitated so permanent staff had to intervene and inform the agency nurse this was how the person liked to eat. According to a health and social care professional assessment another person was meant to be on a special diet supplement because they had lost weight. This person was no longer on the diet supplement and had not been weighed for nearly a month. The clinical lead said this person should still have the diet supplement and should be weighed weekly due to previous weight loss. This was investigated and later the clinical lead explained the agency nurse had phoned up the doctor and cancelled the diet supplement without their knowledge. This person was at risk of losing weight and had not received their diet supplement since the end of December 2015 and their weight was not consistently being measured weekly.

Despite the majority of nutritional plans being completed there were gaps where nutritional needs had not been assessed and plans were not in place. Two people who had moved into the home in December 2015 did not have full nutritional plans in place. One of these people was observed not to eat much at a meal time on the first day of the inspection; a health and social care professional informed us the person's teeth had been lost. By the second day, their teeth were found and they were able to eat more. We spoke to the clinical lead and registered manager about our concerns for this person who needed a special diet and was not seen eating much. Since the inspection, the local authority and the home had discussed this person's nutrition to ensure the person was supported appropriately at meal times. Following the inspection, the provider informed us this person had dementia and hides their dentures.

This is a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were supported to have sufficient amounts to eat and drink and had their nutritional needs met. One person said the food was "Marvellous" and another said, "The food here is good". A member of staff said, "I do feel the residents get enough food, the food is fresh and really good". Daily handover sheets showed how concerns in relation to people's fluid intake had been discussed with staff. Proactive steps had been taken to encourage people to eat and drink. When necessary people's food and fluid intake was monitored; this was the decision of the nurses who made these decisions in line with people's medical needs. Food and fluid charts were completed in full and were generally up to date. The clinical lead said they had been focussing on nutritional needs of people using the service and had provided informal training to care staff that included improving documentation and physical support.

Action was taken when people were identified with complex needs in relation to eating and drinking. When required, people were referred to the dietician and care plans contained details of how staff should support people. For example, one person was provided with finger foods, as they would not sit down long enough to eat a whole meal. We observed staff providing them with small sandwiches to eat as they walked around the building. Other care plans provided staff with information such as details of prescribed food supplements and any requirements in relation to diet texture. The chef was knowledgeable and knew the different needs of people. They had a notice board with details of special diets, including specialist recommendations. For example, the person who was having finger foods that they could eat while walking around was on the notice board in the kitchen.

The home had regular contact with their GP who came in once a week. They had made contact with other professionals for people such as dieticians and opticians. However, when people needed referrals to professionals this was not always done in a timely manner. For example, one person had arrived at the home recently and needed a

Inadequate

Is the service effective?

referral to a specialist nurse to meet their medical needs. The registered manager in their audit had identified this; but the referral had not been made. The referral was made by the clinical lead during the inspection.

Requires improvement

Is the service caring?

Our findings

Most people and their relatives thought the home was caring although there were times when this was not the case. One person said, "Some staff are not good with vulnerable residents and don't seem to understand why the person is behaving." Another person said, "They [meaning the staff] are kind and compassionate and do treat you with dignity and care". A third person said, "If ever I have a problem they always sit down with me and listen to what I have to say". A relative said, "Staff seem very, very caring. They must love the residents". A member of staff told us "I treat them like I would like to be treated" and another staff member said, "We get to know them, see how they want us involved in their care as it's all about them".

The interactions between staff and people using the service were caring most of the time. Staff spoke to people using their name. However, we found a person whose arm cold; they were only wearing a t-shirt and had been sitting in the room for a period of time. We told a member of staff the person felt cold. The staff member agreed it was cold in the room and the person was cold so went to get the person a jumper. We spoke to the registered manager who went to find out if the heating had a problem. They explained that the sun had been out earlier so the room was warmer.

During a mealtime in the main dining room, one member of staff went around people and encouraged them to eat. Nearly all interactions were task based around eating, which meant staff were asking what the person wanted to eat or what they wanted for pudding but not providing social conversation. Other staff members were supporting people in their bedrooms or people who needed close supervision. One person was sitting for periods of around 15 minutes not eating when the member of staff was not with them and no other member of staff in the room noticed this. Another person only received interaction from staff when they asked what the person would like for main course and pudding. We spoke to the registered manager about our observations and saw they had completed some of their own observations as part of the Butterfly Project. Their observations confirmed a majority of interactions were task-based. They said they used supervisions as a way to discuss this with staff and had plans for the activity coordinator to spend more time working alongside staff to promote how to positively interact with people.

People were given opportunities to make choice and these were respected but sometimes the opportunities around choice had not considered the needs of people. During a mealtime, one person who struggled to make choices was asked what they wanted for dinner; due to their medical condition pictures or plates of food would have supported their understanding. On another occasion, a member of staff offered a person some biscuits, but the resident replied, "I can't see them". The plate of biscuits was above the person's head. However, one person said, "They let me lie in bed for another ten minutes if I want". A relative said, "We requested a room downstairs, which they gave us". One staff member said, "I take people's choice seriously. We have to respect their freedom". Another staff member told us "Choices are very important. You and I like different things, so it's the same for the people here". One staff member asked a person "Would you like to try some of this?" Another member of staff asked a person if they wanted more to drink, they returned with two different types so the person could choose.

People's dignity and privacy was maintained most of the time. They were supported with personal care behind closed doors. Staff knocked before entering people's bedrooms and then spoke with them respectfully. For example, one staff member was heard saying, "We are going to move you into a chair in a minute. Is that okay? I'm just waiting for another member of staff to come along. Thank you". On another occasion, a person was helped to transfer between two seats because they were unable to do it themselves and staff provided reassurance as they appeared scared. They made sure the person's dignity was protected throughout. However, there was one person who required assistance with personal care and was left lying on their bed; a member of staff said the person would have to wait because other staff were having their break. The registered manager said they used observations to monitor staff delivering good practice and protecting dignity when they were caring for people.

The nurses and activities coordinator were in the process of rewriting people's care plans. Due to the medical conditions of most people in the home, they were unable to participate fully in deciding how their care was delivered. In these cases, the provider was asking relatives and where there was no relative, they were sourcing an advocate. An advocate is someone who acts as the voice for the person. Sourcing advocacy was proving difficult in some cases so a member of staff who knew the person well was involved.

Requires improvement

Is the service caring?

We saw most people had memory boxes, which contained important objects to trigger memories. This was important because most people had medical conditions requiring their long-term memory to be supported. In some people's bedrooms there was a brief description of people's life story with photographs on their notice board. Some care plans contained people's likes, dislikes, and a 'This is me' document. This is a piece of work about people's history, likes and dislikes before the home. For example, one person's file had the person's history written up including where they worked and they enjoyed going fishing.

On the first day of inspection, there were no visitors, except for the new person moving in, because there had been an infection in the home. During the second day of inspection, we saw visitors freely coming and going to see their loved ones. Staff welcomed visitors in the home and the visitors were free to go where they wanted.

Inadequate

Is the service responsive?

Our findings

At the previous inspection, there was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always receiving care in line with their care plans. We also found staff were unfamiliar with people's care and had not read their care plans. Following the previous inspection the provider told us all staff were in the process of reading all care plans thoroughly and familiarising themselves with them. They also explained they had been sourcing advocates to ensure care plans were devised with consent of the resident or in their best interest.

The registered manager and clinical lead told us that care plans were currently being updated and rewritten. Most staff said they still had not had time to read care plans and in addition they had recently been rewritten so staff had not had chance to make themselves familiar with updated information. One member of staff said, "I've not read all the care plans, but read most". Another member of staff told us they wished they had more time to read the care plans. A third member of staff explained staff had been told to read the care plans a few months ago, but said they were busy so did not have the time. When staff were asked how they could identify people's likes and preferences staff told us they would collect information in a variety of ways. For example, spending time with them, looking at their reactions to things offered to them and if they keep rejecting what they offer they would try something else or get information from the person's family.

Each care plan had a staff list at the front for staff to indicate they had read the care plan but the majority of these had significant gaps. For example, one person had six staff members' signatures out of 23 care and nursing staff whilst other care plans had lists where up to 19 staff had not signed to say they had read them.

Two people had recently moved into the home but neither had a full care plan yet because nutritional plans were not completed. However, there were malnutrition screening tools being used and the full care plans were in the process of being written. In addition, one did not have a falls risk assessment, an assessment for pressure care and did not have any weight records. This meant they were at risk of not having their needs met and one of these people had not received care in line with their needs. For example, A nurse had documented in one person's care plan their feet and ankles were swollen so should be elevated to relieve the swelling and discomfort. Throughout the inspection, the person did not have their feet elevated. Their turning and positioning charts had records for their positions overnight and there was nothing for during the day. On another date, the records showed this person had been sat in the same position for seven hours with no position changes. This meant the person was not having their pressure relieving needs met by staff so there was an increased risk for this person of developing pressure sores.

Some care plans were not written in a way to support staff keeping people safe. For example, a person's care plan documented the person wanted to maintain their privacy during the night; it said, "Puts chair up against [their] door to stop other residents going into [their] room". The care plan stated this practise had been risk assessed but the provider has not completed a risk assessment. Staff said the person no longer felt the need to block entry to their room, but the care plan had not been amended to reflect this. Following the inspection, the provider told us there had been a hand written risk assessment in the person's care plan which was removed when the behaviour ceased; we did not see it. There had been an incident when another person had fallen behind their bedroom door and blocked it, so staff were unable to access the room without the fire brigade's assistance. Following this incident, the registered manager had reported the incident to the local authority safeguarding team and to the Commission. Despite this incident the registered manager had not identified the practise of blocking a door with a heavy object such as a chair would prevent entry for staff so was a risk to the person's safety.

Few care plans were person centred, which means the person's needs and wishes are central to their care. Although some contained "This is Me" booklets, not all did; these books contained information about people including their history, likes, dislikes, family and previous employment.. In one person's plan, it was documented that staff should "Offer encouragement to take pride in personal appearance" but there was no other supporting information or guidance for staff. In the same plan, the person's interests were listed as "Listening to music, entertainment, reading and watching TV". But there was no information about the types of music and television programmes the person preferred or whether they could still read unaided. Another person's plan informed staff to

Inadequate

Is the service responsive?

"Sit quietly with [person's name] and chat to them about anything and everything. Enjoys films" so there was a lack of detail around what specific films this person enjoyed or what particular themes this person enjoyed talking about.

We asked a member of staff where a person liked to eat. The staff member said the person eats in the lounge area of the dining room and showed us the chair. At lunchtime, the person was eating in a different room. Another member of staff said they thought it was better they ate there because it was quieter. The staff member agreed there was nothing in the care plan about this. This meant staff would struggle to know the preference of this person because it was not clear in their care plan.

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

People and their relatives had mixed views about activities in the home. One person said, There is no list of activities". They continued to explain a visitor comes to play the piano and sing with them. Another person told us if they want to go for a walk, they have to tell the office in case there is a fire. One of their activities was going to the shop to buy magazines and cigarettes. A relative said, "They do all sorts of things" when asked whether there were activities. This relative continued to explain there had been "A chap with an accordion singing all these old songs. My [relative] loved it".

We saw memory boxes or individual activities such as dolls and fiddle toys on people's tables. These were being organised by the activities coordinator who said, "Every day I go to each resident's room and see if they have the music they like and their memories in front of them". We saw the activity coordinator made sure they supported as many people as possible. They went round people making sure they positively interacted with them including giving them objects such as dolls and fiddle toys. They had been proactive about making contact with the local church and finding activities out of the home. However, the activity coordinator did not feel they had enough time or resources. When the activity coordinator was not around there were less activities occurring. We spoke to the registered manager who said they were making sure the activity coordinator did some more one-to-one sessions with members of staff. This was to encourage them to participate more in the Butterfly Project style activities.

People's views on the quality of the service were sought and shortfalls had been identified but not all actions had been completed. One person said, "I have not seen any relatives or residents meetings". The registered manager said they had tried to hold residents and relatives meetings but the attendance was poor. They had offered more informal cheese and wine evenings. The provider had sent surveys to staff and relatives. An action plan had been created from the staff survey. Whilst some of the actions had been completed and signed off not all of them had. Staff had asked for challenging behaviour training; the action plan said, "Still not sourced but needed".

There had been two complaints recorded since the last inspection. One was as a result of a safeguarding investigation but the actions to reduce the risks had not been completed. The second complaint had just been received. The registered manager had responded promptly to acknowledge receipt of the complaint and had followed the provider's complaint policy.

Inadequate

Is the service well-led?

Our findings

At the previous inspection, there was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Despite audits having been completed by the registered manager, shortfalls were not being identified and resolved. Staff had not received training they required to carry out their duties and there had been delays to safeguarding notifications being received by us. Care records were not being stored securely and staff were not delivering care in line with people's care plans. Since the previous inspection the provider and registered manager told us there had been regular audit meetings; they said all audits were completed and were part of a new regime. They told us care plans were now stored securely and staff were reading the care plans and familiarising themselves with them. The provider said staff had received further training in how to appropriately approach people when a person was displaying behaviours which challenged.

On the latest inspection, we found there had been some improvements in the home. There were now regular audit meetings between the registered manager and provider. The care plans were now stored securely in a locked cupboard in the nurses' office. Staff had received some training and there were planned dates for incomplete training. However, audits had not identified shortfalls found on this inspection and there was incomplete training for staff in challenging behaviour. The delivery of care was not always in line with people's care plans and some people had incomplete care plans. Staff told us they had not read all the care plans.

The home had a reactive approach, which meant people's care and staff's health, and safety was at risk. The provider only responded to concerns when outside agencies raised them. We noted on the second day of our inspection observations we made on the first day led to changes being made. For example, the cleaner on the first day was using only a blue mop, which was not meant for toilet areas, and working without an apron or gloves; on the second day the cleaner was using a red mop for cleaning en-suite bathrooms and wearing an apron and gloves. We found the inner lift doors were not closing properly and people and staff could have caught their limbs or clothing against a wall whilst it was moving. This was raised with the registered manager on the first day who was not aware of the problem and they contacted an engineer to fix it. On the first day, we saw most of the air pressure mattresses were either under or over inflating. By the second day, some had been adjusted to a more correct setting. However, this had been a concern raised in a safeguarding concern in October 2015 and discussed at a manager's meeting in November 2015 where the provider said it had already been rectified.

People's safety was at increased risk because audits were not identifying shortfalls. In November 2015, the registered manager completed an audit for infection control and prevention. The audit recorded posters were in place demonstrating the display of correct hand washing techniques in communal hand washing areas. Three communal wash areas we viewed did not have any written guidance on cleaning hands. The audit recorded all toilet areas pedal bins were foot operated. The three toilets we viewed had ordinary round plastic open bins. We raised concerns with the registered manager about infection control and they agreed these things should not happen.

When audits had identified problems there had not always been actions taken. The provider had employed their own compliance officer who completed care plan audits and audits were not present for all care plans. There was no audit overview for care plans to ensure all people's care plans had been checked periodically. Care plans that had identified shortfalls had actions created to rectify them. However, there was no record these actions had been completed. For example, in September 2015, three care plans were audited; two people had two incomplete actions and one person had four actions not signed off. In October 2015, one person's care plan had no actions signed off. Some of the actions identified the clinical lead was responsible for them; the clinical lead was unaware of the actions assigned to them. This meant the leadership did not have an effective system to ensure identified actions were completed.

We spoke to the registered manager about how they were tracking the individual action plans from specific audits. They said there was no whole home action plan incorporating actions from other audits, but think it is something they might complete in the future. They told us they had just completed an annual home review audit and that they were going to write an action plan. However, the whole home audit completed in December 2015 had failed to identify many of the shortfalls found during this

inspection. For example, the audit said, "All staff files contain two satisfactory references" and was ticked yes but not all staff had two references. Another entry said, "All bed rails in use have been fully risk assessed" which was marked as "yes" and we found they had not. When the registered manager had identified a shortfall in the whole home review audit, they had not acted upon it. For example, it recognised in December 2015 that there should be contact with a specialist nurse in relation to a pressure wound; no contact was made until after the first day of inspection in January 2016 when the provider had been prompted. This means even though there were audits occurring in the home they were not ensuring shortfalls were rectified or identified. As a result, this was affecting the safety and welfare of people living at the home.

Since the last inspection, the provider was now holding regular manager and audit meetings. The registered manager attended these and a registered manager from the provider's other home. Identified shortfalls did not always have completed actions. For example, the November 2015 provider's audit meeting identified incomplete actions from the October 2015 care plan audits. The registered manager and provider had highlighted these would be discussed in a trained staff meeting but had not identified when these actions would be completed or if they had. During another management meeting in November 2015 it was agreed weekly night checks would be put in place to help mitigate the risk of a safeguarding reoccurring. This had been highlighted in the actions at the end of the meeting; no rota had been created and only two night checks had occurred to date despite a management meeting in December 2015 stating, "Reviewed actions from previous meeting". This means even though the provider was monitoring the home and identifying actions needing to occur; they were not always ensuring they had happened.

The home had embedded the Butterfly Approach into the way they supported people. This meant there was an expectation around interactions staff had with people. The approach promotes positive social interactions and not task based contact. During our observations, the activity coordinator and registered manager were promoting this way of interacting. This included engaging people in conversations and speaking about topics they wanted to whether it was from the present or past memories. Other staff were interacting on a more task-based level. We found observations the registered manager had completed as part of the accreditation to the Butterfly Approach, which reflected our observations. The registered manager had recorded them as being mainly neutral or negative interactions. We spoke to the registered manager to find out why there did not appear to be improvement over the months. They explained they were particularly harsh when completing observations, but had noticed an improvement in staff. However, they said it depended upon the day they did them because if the home had more agency staff on that day or the room was too busy it could affect the outcome. The registered manager agreed this could always be improved so had plans to have the activity coordinator spending more time with staff to share how to interact with people more positively. We asked if there was an action plan written about these planned improvements, there was not. This meant even though shortfalls were identified and plans considered to improve them no action had been taken.

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

People and relatives were positive about the home. One person said, "It's got a really homely feeling in this care home. You feel the same way as if you are in your own house". Another person told us "This is a nice place to be. There is nothing to change here". A relative said "The [registered manager's name] seems to know what is going on". A second relative said "Find [the home] nice atmosphere and not too big". The culture of the home was clear and the staff understood they wanted a homely feeling. The registered manager and provider were both active around the home. During the inspection, they were both present. One relative explained to us that it was unusual to be in a home where the owner [meaning the provider] is around. We saw the registered manager interacting with residents and staff throughout the inspection even though her office was in the basement. One relative explained it was nice to see management because some homes you go to they are never there.

The provider has submitted notifications to us which help us monitor what is happening in the home. This includes information about safeguarding and changes occurring in the home. The registered manager had a record of all the notifications that had been sent to us and, where appropriate, details of outcomes. This meant we were able to follow up information to keep people using the service safe.