Ocean Cross Limited

Grace Lodge Nursing Home

Inspection report

Grace Road
Walton
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Website:

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Ratings

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

Overall summary

This unannounced inspection of Grace Lodge Nursing Home took place over three days on 11, 12 and 18 March 2015.

Grace Lodge Nursing Home is a care home that provides accommodation, nursing care and treatment for up to 65 adults who have nursing care needs. Accommodation is provided over two floors and the home is accessible to people who are physically disabled. Access to the upper floor is via a staircase or passenger lift. The service is situated in the Walton area of Liverpool. It is in close proximity to local shops, other local amenities and public transport links.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

We found that people who lived at the home were not fully protected from potential abuse. This was because care staff told us they did not feel confident to raise concerns for fear that they would not be supported. We also found that lessons had not been learned from the outcome of safeguarding investigations and changes to practice had not been adopted to prevent reoccurrences of abuse. You can see what action we told the provider to take at the end of this report.

People's needs were not appropriately assessed before they were admitted to the home. The quality of information in care plans was poor as they did not provide sufficiently detailed information/ guidance on how to meet people's needs. Other records about people's care and treatment, such as wound care charts, were poor and failed to demonstrate the care and treatment provided. You can see what action we told the provider to take at the end of this report.

We saw and heard that staff worked well with local health care professionals to make sure people received the right care and support. However, we also saw examples whereby people were not being provided with the right care and support. You can see what action we told the provider to take at the end of this report.

Medication was not managed appropriately or safely. Information about people's needs with medication was poor and failed to provide appropriate guidance to staff. You can see what action we told the provider to take at the end of this report.

The manager told us they and senior members of staff had been provided with training on the Mental capacity Act (2005) and they were able to demonstrate an understanding of the principles of the act. However, we found there was no consistency in how the principles of the act were applied in practice. We have made a recommendation for the provider to review how the home is working within the legislative framework of the Mental Capacity Act (2005).

We received mixed feedback about staff and how people felt about the support provided by staff. Some people described staff as 'kind', 'caring' and 'lovely'. Other people told us they felt some of the staff did not care about them or treat them well.

There were not sufficient numbers of registered nurses employed to work at the home. The use of agency was high as agency staff were being used to cover registered nurse vacancies. We also found there was a high turnover of staff including registered nurses. At our previous inspection of the service on 13 August 2014 we had found the provider was in breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 because there were not enough suitably qualified, skilled and experienced staff employed at the home. We found the provider had not met the compliance action we gave and was still in breach of this regulation. You can see what action we told the provider to take at the end of this report.

Staff were only employed to work at the home when the provider had obtained satisfactory pre-employment checks. This assists employers to make safer decisions about the recruitment of staff and aim to ensure staff are suitable for their role.

Staff generally told us they had been provided with the training they needed to carry out their roles and responsibilities. However, the majority of staff we spoke with told us they did not feel supported in their role and we found that staff were not always being provided with regular supervision. You can see what action we told the provider to take at the end of this report.

The home was accessible and aids and adaptations were in place in to meet people's needs and promote their independence. The premises were well maintained. However, not all appropriate procedures were in place to protect people from hazards. For example, we found there had been a long gap between fire drills having been carried out and water temperatures were not being checked correctly. Not all areas of the home were clean and not all staff had up to date training in infection control. You can see what action we told the provider to take at the end of this report.

The provider did not have effective systems in place to regularly check on the quality of the service and ensure improvements were made. Improvements were not being

Summary of findings

made in response to complaints, feedback from staff and feedback from health and social care professionals. You can see what action we told the provider to take at the end of this report.

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.

People were not fully protected from the risk of abuse because staff did not feel supported to raise concerns and appropriate action had not always been taken following investigations of abuse.

People's medicines were not being managed safely and people were at risk of not being administered their medicines as prescribed.

Pre-employment checks were carried out on staff before they started working at the home to ensure they were deemed suitable to carry out their roles and responsibilities.

There were insufficient numbers of suitably trained and experienced staff working at the home.

Infection control practices were not always being carried out appropriately and there were gaps in staff training in infection control.

Is the service effective?

Inadequate 

The service was not effective.

Staff were not being supported through regular supervision or attendance at team meetings.

The manager had some knowledge and understanding of the Mental Capacity Act 2005 but they were not applying it effectively to ensure decisions were made in people's best interests.

Staff referred to local health care professionals for advice and support to meet people's needs. However, we found that people were not always provided with the right support they needed to protect their health and wellbeing.

The food and meals provided were not always of a good standard.

The home was accessible and aids and adaptations were in place to meet people's needs and promote their independence.

Is the service caring?

Requires Improvement 

The service was not always caring.

People who lived at the home told us that staff were generally good but some people reported that a number of staff did not always have a caring attitude towards them.

We saw staff supporting people in a caring and respectful way. However, staff did not always speak about people appropriately.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

Each of the people who lived at the home had a care plan. However, we found people's individual needs were not reflected in their care plan.

Care was not always well planned and co-ordinated between services.

There was no learning from complaints and investigations. Recommendations from outside professionals had not been acted upon to ensure improvements were made to the service.

Is the service well-led?

Inadequate 

The service was not well-led.

The systems in place to check on the quality of the service were ineffective. They failed to identify shortfalls or ensure those that were identified were acted on.

The culture within the home was described to us as 'not open' and 'not good'. Many of the staff team told us they felt they were not listened to and they felt unsupported in their roles and responsibilities.

Grace Lodge Nursing Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 11, 12 and 18 March 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse with experience of this type of service.

We reviewed the information we held about the service before we carried out the visit. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make.

Prior to our inspection we contacted one of the commissioners of the service to gain their feedback about the service. We also contacted the local authority residential care home social work team and the local medicines management team. During the inspection we met a number of visiting health care professionals who were attending the service and we sought their feedback about aspects of the service. Following the inspection we also contacted a number of other health care professionals who worked into the home and who had knowledge of the service.

We met many of the people who lived at the home during the course of the inspection and we spoke at length with 15 people. We also spoke with nine visiting relatives, 10 members of the care staff team, four registered nurses, the registered manager and the nominated individual (a person registered with CQC). 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.

We viewed a range of records including: the care records for five people who lived at the home, four staff files, records relating the running of the home and a small number of policies and procedures.

We carried out a tour of the premises and this included viewing communal areas such as lounges, dining rooms and bathrooms. We also viewed a sample of bedrooms with people's permission.

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Is the service safe?

Our findings

We asked people who lived at the home if they felt safe. The feedback we received was mixed. The majority of people we spoke with told us they did feel safe. One person said, "The staff are good they take care of me." Another person said "The staff are very respectful." However, one person told us they felt the staff were not kind or compassionate towards them.

An adult safeguarding policy and procedure was in place. This included information about the types of abuse and guidance for staff about the actions to take in the event of an allegation of abuse. The manager was aware of their responsibilities to report allegations of abuse to relevant authorities such as the local authority safeguarding team, the police and the Care Quality Commission (CQC). We asked a registered nurse to tell us about their knowledge about safeguarding. They told us they would investigate an allegation and would report it if it was deemed to have taken place. This is not in line with adult safeguarding procedures. We found this member of staff had not been provided with safeguarding training and they had been in post for six months.

We looked at the home's safeguarding records. We found there was no record of at least two safeguarding investigations that we were aware of. One of these was current and one related to a safeguarding allegation investigated over 12 months ago. Prior to the inspection visit we reviewed the safeguarding information we had received about the service since our last inspection. We found examples whereby the findings of investigations had identified shortfalls in the service and the manager had agreed to implement new practices as a result. However, during the course of our inspection we saw that these had not been implemented. For example, the manager told us that a registered nurse would be provided with up to date training in administering medication following a medication error which resulted in a safeguarding investigation. This had not been provided. In another example the pressure settings in air flow mattresses had been identified as requiring regular checks. These had not been implemented and during the course of our inspection we found mattresses were being used with incorrect settings. These mattresses are used to prevent people from developing pressure wounds. If they are not used correctly then people are at risk of developing pressure areas/ wounds. In another example the manager had agreed to ensure the regular supervision of a member of staff and to ensure they underwent training in dignity and respect. These had not been provided.

Care staff told us they were confident about recognising potential abuse and they had been provided with safeguarding training. However, the majority of staff we spoke with said they did not feel confident to 'whistle blow' if they had concerns because they did not feel that they would be protected if they did so. During the course of our inspection the police were in attendance at the home investigating a safeguarding allegation. We also heard from a person who lived at the home that they had a concern about the way in which a member of staff had treated them and they said another member of staff had witnessed this. The manager told us they were not aware of this and therefore no action had been taken and the allegation had not been reported to the local authority safeguarding team.

We found that the registered person had not protected people against the risk of abuse and improper treatment through operating effective systems to prevent abuse. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication was not managed appropriately or safely. The home had a medication policy and procedure and medication was only administered by registered nurses. We found a number of concerns with the practices in place for managing medicines. Medication administration records (MARs) were not being completed accurately. We saw gaps in the MARs and therefore we could not always establish if people had been administered their medicines as prescribed. We also saw that staff were using codes on the MARs which were inaccurate. We found information about people's medicines and why they needed them was not being recorded appropriately in their records. For example one person had been prescribed a controlled drug. These are prescription medicines that have controls in place under the Misuse of Drugs legislation. This had been recorded in the controlled drug register but there was no record of it on the person's MAR chart or on any other records. The manager told us why the medication had been prescribed and it was to be used in the event of a serious medical condition. The information about this drug

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Is the service safe?

and why it was prescribed was crucial for the well- being of the person. The fact that this information had not been recorded anywhere was of serious concern. This was compounded by the fact that the home was using a high level of agency nurses who would not have access to information and guidance about the medication and would not see that the person had been prescribed it.

We asked people who lived at the home if they felt well supported with their medicines. We received mixed feedback. People's comments included "I get my medication on time", "No problems I get it regularly", "They forget my medication" and "I've had to wait more than an hour for the nurse to come back to me with it."

We found that it was not always possible to check that people had been administered their medicines as prescribed. This was because medicines carried over from the previous month had not been recorded on the MAR. The provider was therefore not able to carry out an accurate stock check and establish if people had been given their medicines as prescribed. We found that for one person a supply of warfarin tablets was in excess of 50 tablets over. We saw there were numerous boxes of warfarin open and this added to the difficulties in assessing stock control. We looked at the medication audits carried out over the past five months. The last audit was carried out on 24 February 2015 and the manager scored the management of medicines at 97.43%. Previous audits scored similar scores and one scored 100%. The manager's audit had detailed that there was a sufficient method of stock control in place. This was not in line with our findings. The home had been subject to an audit by the local medicines management team in January 2015. The manager told us they were working to an action plan to address the concerns found as part of this. However, we found that errors and poor practices which had been identified by the local medicines management team had not been addressed.

We saw that eye ointments had not been dated as to when opened. These have a shelf life once opened and it is therefore important that this information is recorded. We saw a box of medication which had no label on. We found a medicine pot in the medicines trolley with loose tablets in. The nurse on duty did not know why these were there or who they were prescribed for. We saw gaps in the fridge temperature monitoring records.

We saw one person was self -administering a medication. We found that a risk assessment had not been carried out regarding this. The person's care plan stated that they were not able to administer any of their own medicines. The manager's medicines audit detailed that none of the residents self -administered their medicines. They were therefore not checking that the practice was safe.

We found that a number of people who lived at the home required the use of oxygen. One of the people we met had nasal specs on which were attached to an oxygen cylinder. However, we found that the oxygen cylinder was not switched on and upon further examination we found that the oxygen cylinder was empty. Nursing staff told us this person did not require oxygen. The person told us they required oxygen and could not move without it. We told the manager to take immediate action to clarify this and to report our concerns to the local safeguarding team and commissioners of the service.

One person we spoke with told us they were in pain. We brought this to the attention of the nurse on duty. The nurse was a member of bank staff who worked at the home infrequently. The nurse said they would request a review of the person's pain relief medication from their GP. However, we found the person had been prescribed more powerful pain relief medication (a controlled drug) two days prior but the nurse on duty was not aware of this despite the fact that they had carried out the medication round that morning. There was no guidance on the person's records about this medication in terms of when it was required or if it should be offered as part of the medicines round. The nurse on duty the previous night had been an agency nurse. We were concerned that information about people's needs was not being communicated effectively between staff. We saw that people's care plans included a section about the support they needed with their medicines. However, the information in these was mostly about the home's procedures for managing medicines and not about the individual needs of the person concerned.

We found that the registered person had not provided care and treatment in a safe way by ensuring the safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Is the service safe?

We found a number of shortfalls in cleanliness of the home and in infection control practices. We found arm chairs which were in various states of disrepair and were dirty. The sluice was also dirty. Both of these matters had been picked up in an infection control audit carried out by the local infection control team in September 2014. Our findings therefore showed that the recommendations from the infection control audit had not been implemented. We also found that two, of the sample of pedal bins we checked, were not working. Mattresses were not being cleaned appropriately. One mattress we saw was heavily soiled both inside and outside this was removed during the course of the inspection. The bases and wheels of hoists were dirty and nobody was responsible for cleaning these and checking they moved smoothly. We saw a number of commodes which were soiled and generally dirty. Several commodes were seen in bedrooms with no covers and nobody knew who was responsible for cleaning them. Overall, we found there was a lack of accountability amongst staff as to who was responsible for checking, monitoring and cleaning equipment which presented an infection control and safety risk.

We found that the registered person did not have effective systems in place for assessing the risk of, and preventing and controlling the spread of infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's welfare were recorded in their care plan. However, we found these were not always being carried out consistently. For example, some risk assessments had not been completed when it was evident that they were required. Some people had bed rails on their beds but there was no risk assessment for the use of these or any evidence that people had agreed to use them. Risk assessments had been carried out with regards to safe working practices and a number of control measures were in place to manage identified risks. However, we found some health and safety checks had not been carried out appropriately. For example, water temperature checks showed that water temperatures were not being maintained to an appropriate level. The temperature of water in one of the baths and in people's bedroom sinks was hotter than recommended and was hotter than the water in the kitchen. Water in the kitchen was not meeting the required temperature. We also saw there was a gap in the fire drill register which indicated that fire drills where not being carried out at regular intervals. We also found there was a lack of accountability for ensuring some health and safety checks were carried out. For example, the checking of mattress settings and checking hoisting equipment.

We found that the registered person had not carried out appropriate checks on the premises or equipment. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who lived at the home to tell us what they thought about the staffing levels. People gave us mixed feedback. Their comments included: "When I press my buzzer the staff come quick", "Yes they are pretty good and get to me as quickly as they can", "If I press the buzzer I can wait from 10 minutes to an hour before anyone comes" and "Once when I wanted the toilet they told me it was dinner time and I would have to wait, I told them I could not wait so she told me to do it in my pad." A relative told us "If the home was better managed and they had more staff perhaps I would not worry about my [relative's] care I have had to wait up to 45 minutes for food for [relative], I wonder if they forget when I am not here."

At our last inspection of the service in August 2014 we gave the provider a compliance action because we found there were not enough suitably qualified, skilled and experienced staff employed at the home. This was because there was a shortfall in the number of qualified nurses employed at the service. At the time of the last inspection this shortfall amounted to five full time equivalents over both day and night shifts. Following the inspection, the manager confirmed that registered nurses had been employed to fill the majority of vacancies. However, during the course of this inspection we found that there continued to be a number of vacancies for registered nurses and one nurse was working their notice. The vacancies were on nights and meant that over a one week period 11 of the 14 night shifts were being covered by agency nurses or bank nurses. Staff told us this had an impact on the people who lived at the home because the agency staff did not know people's needs. Agency staff were also being used to cover care staff

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Is the service safe?

on nights. This meant that the home could be running on a majority of agency staff throughout the night. Care staff told us that this had an impact on people who lived at the home. They told us that there had been occasions when they arrived on shift in the mornings that they had found people had not been supported appropriately with their continence needs through the night. We saw that this has been the subject of a number of complaints about the service made by relatives.

At the time of our inspection there were 57 people living at the home. The vast majority of these people required nursing care. Nursing staff and care staff told us they supported a high number of people who required palliative care (medical care for people who have a serious illness) and they felt the staffing levels were not sufficient to meet people's needs. All of the nurses we spoke with told us there were not enough nurses on duty. They said they had raised this with the registered manager but the nursing levels had not been increased. We asked the registered manager and registered person at what point they increased the number of nurses. They told us this was when the home was at full capacity. However, we found that nursing levels had never been increased even when the home was running at full capacity and this was confirmed during discussions with nurses. Nurses told us they were not able to keep up to date with care plans and other records because they did not have time.

Care staff told us they did not have time to spend with people outside of providing personal care and we saw this was the case during the course of our inspection. They told us they were sometimes short staffed due to staff sickness or staff accompanying people to hospital appointments. They told us shortages were not always covered.

We found that the registered had failed to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff deployed at the home. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment records. We found that appropriate checks had been undertaken before staff began working at the home. We found application forms had been completed and applicants had been required to provide confirmation of their identity. We saw that references about people's previous employment had been obtained and Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

Inadequate

Is the service effective?

Our findings

People who lived at the home gave us mixed feedback about the quality the care and support they received. The majority of feedback was good but we did receive some negative comments. People's comments included: "If I need a doctor they will get me one and if I have to go to the hospital a carer will take me", "The staff are pleasant and supportive", "The staff keep me informed about everything", "I feel that the staff are not trained properly" and "Some staff are trained well and some have no idea."

The majority of relatives we spoke with gave us good feedback about the home. Their comments included: "It's great here, they are very good", "They look after my [relative] very well. I have no complaints at all" and "I don't have to worry about my [relative] I know they are being well looked after." However, some relatives also gave us negative feedback and told us they had complaints about their family member's care.

We found that the home worked well alongside local health care professionals. We saw that staff had regularly referred people for physiotherapy, occupational therapy, speech and language therapy, tissue viability support, dietician support and district nursing services in line with their needs. We observed one of the registered nurses interactions with a number of visiting health professionals. They welcomed people warmly, demonstrated knowledge of the needs of the people who lived at the home, communicated relevant information clearly to them and accompanied them to see people. We spoke with each of the professionals who visited and asked them about their experiences of visiting the home. They were all very positive about how staff reacted to their suggestions. They told us they felt comfortable when visiting and believed that their instructions would be followed. One professional told us staff were 'brilliant', 'welcoming' and that they communicated well. Another told us 'We plan care together with the nurse'. Another told us they had a good relationship with staff and that the nurse on duty was able to provide accurate and reliable information about people who lived at the home which 'made their job easier'.

However, we found that people were not always provided with the support they needed to protect their health and wellbeing. Two people did not have suitable chairs and this presented a risk to their welfare. For example one person was at risk of their health condition worsening by remaining in bed but they were being nursed in bed because the home did not have the right chair they required to sit in. This increased the risk of them developing a complication with their health. The manager told us they had requested an assessment for chairs but we saw no evidence of this. Another person told us they could not get out of bed without a supply of oxygen. However, we found that staff had not made a provision to ensure this was available to the person or to appropriately clarify the advice from professionals around the use of oxygen for the person. We saw that one person required weighing weekly but this had not been done. The weight record we looked at indicated that the person had lost almost 9kg within one month. The nurse on duty said that she had not noticed this amount of weight loss and the person was reweighed during the course of our inspection and they had sustained a much smaller weight loss. We had found that the person was not being weighed as regularly as deemed required and when they were weighed it was inaccurate and no action had been taken to clarify this or rectify it. People were being nursed on air flow mattresses to prevent them developing pressure areas/wounds. We found the mattress settings were not correct. We found that nobody had taken responsibility for determining what the correct setting should be and there were no checks in place to ensure the settings were correct. We know from information we had received about the service that the checking of mattress settings had been given as a recommendation following a safeguarding investigation in 2014.

We found numerous shortfalls in how the service demonstrated that good quality care and support was provided because the records about people's care were not being maintained appropriately. For example, people were being provided with wound care. However, the wound care records were poor. People were being provided with support with positional changes to reduce the risk of pressure wounds or further deterioration of pressure wounds. But the charts used to record when people had been turned were not being completed consistently. This could indicate that people were not being assisted appropriately. We had identified this as a concern at our last inspection of the service. However, we found this had not been acted upon appropriately.

We found that the registered person had not protected people against the risks of receiving care or treatment that is inappropriate. This was in breach of

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Is the service effective?

regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During discussions with staff they generally told us they felt they had the training and experience they needed to meet people's needs. A number of staff told us they had requested some additional training in topics such as palliative care but this had not been provided to date. Staff told us the training they had been provided with included: first aid, moving and handling, food hygiene, safeguarding adults, fire safety and dementia care. Staff files contained training certificates that confirmed this. The registered manager shared a copy of a training matrix with us. This gave us an overview of the training across the staff team and showed us that updates for training in food hygiene, health and safety and infection control had been scheduled.

A member of staff told us they had received a good induction when they started working at the home and they felt it was sufficient to give them the core skills and knowledge they required for their role. They told us they had shadowed a senior member of staff as part of their induction and that this gave them the opportunity to get to know people's needs.

We received mixed feedback from staff about the support they received. Some staff told us they felt fully supported but the majority of staff we spoke with told us they did not feel well supported. They told us this was because they would not feel confident to raise concerns because they were concerned that they would be identified as having done so. They also told us they felt when they raised matters they were not listened to and their requests/ concerns were not acted upon. This feedback was echoed in the results of a staff survey carried out in 2014. We saw that the provider had carried out an analysis of the staff survey but we saw little evidence that they had taken action to address the concerns raised.

We found some of the systems in place to support staff such as supervision and team meetings were not being carried out on a regular basis. For example the file for a registered nurse showed that they had not had a supervision since they started their employment six months prior. Staff meetings were only being carried out sporadically. The last general staff meeting had been held 14 months prior. We saw some recent meetings for different groups of staff but the ones prior to those had been held a significant time ago.

We found that the registered person had failed to ensure staff were appropriately supported to carry out their roles and responsibilities. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they and senior members of staff had been provided with training on the Mental capacity Act (2005). They were able to demonstrate an understanding of the principles of the act. However, we found there was no consistency in how the principles of the act were applied. For example we saw that two people were being referred to as having dementia. We saw no reference to this on their pre-admissions assessment or care plan. There was no information as to how this affected people's lives and ability to consent. We saw no guidance for staff on how best to support people with their dementia or with issues of consent. The manager advised that there was nobody living at the home who was subject to a Deprivation of Liberty Safeguard (DoLS). However, we saw a person who may have been being restricted but this had not been recognised and acted upon. The Deprivation of Liberty Safeguards (DoLS) is a part of the Mental Capacity Act (2005) that aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

We recommend the provider reviews their current practices for how they implement their responsibilities under the Mental Health Act (2005) to ensure the home is working within the legislative framework of the Act.

We looked at how people were supported with food, meals, drinks and maintaining a balanced diet. The feedback we received about the food was mixed but the majority of feedback was that the food and meals were not of a good quality. We spoke with people prior to their mealtimes and we asked them what they were having for their meal. We found that people did not know and they only found out when their meal was presented to them. People told us

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Is the service effective?

they were sometimes asked to make a choice of meals prior to mealtime but this was not consistent practice. We arrived at the home at 9.30am on the first day of the inspection. Upon arrival we found that most people were having breakfast and a hot drink. Breakfast was a choice of cereal or hot cooked breakfast. We saw that the lunchtime meal was soup and sandwiches with the odd person being provided with an alternative. We viewed the menu and saw that for 27 days out of the 28 day (4 week) menu the lunchtime meal was soup and sandwiches. Staff told us the quality of the meals was variable. They told us on some days there was home-made soup and fresh vegetables and on other days it was packet soup and frozen or processed vegetables. We tasted the lunch on the first day of our inspection and we found it was bland and unappetising. The only option of bread was thick white sliced and the soup was packet mix and watery. We also noted that the portions were not very big. Staff told us this was often the case and they had to stretch the portions to make them go around. On the final day of our inspection we saw the quality of food looked much better and people were served an appetising evening meal.

We observed a number of people being supported with their meals. The dining rooms on both floors were stark rooms with no atmosphere. One room adjacent to one of the dining rooms was referred to as the 'feeder's room'. This terminology is inappropriate and does not respect people's dignity. We saw that staff took their time in supporting people with their meals but we did see one occasion when staff were talking to each other over a person whilst supporting them with their meal.

We visited people who were being nursed in bed as a result of their frailty. We found people had been supported to have meals and drinks throughout the day. However, we found staff were not always keeping an accurate or meaningful record of what people had had when this was required.

We found that the registered person failed to provide people who lived at the home with a choice of suitably nutritious food in sufficient quantities. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The accommodation was provided over two floors. Access to the first floor was provided via a staircase or passenger lift. The building was fully accessible and aids and adaptations were in place to meet people's mobility needs and promote their independence. Some of the staff told us they would be able to meet people's needs more effectively if they had an extra hoist on the first floor of the building. We relayed this to the manager during our feedback.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home gave us mixed feedback about how caring the service was and about the way they were treated but the majority of feedback was positive. People's comments included: "The staff are kind and caring, they communicate well", "The staff are lovely, amazing", "They talk to you not at you", "Its first class", "They ask me", "They treat me with dignity and respect", "The staff are like friends" and "The staff are excellent and very sociable." However, a small number of people told us they felt staff did not always listen to them and felt that staff did not always behave in a way that made them feel that they cared about them. We spoke with the manager about this and advised that they refer for a review of one person's care.

Relatives also gave us mixed feedback about whether the service was caring. Most relatives told us they thought the staff were caring. Their comments included: "I feel confident that my (relative) gets good care when I'm not here" and "I can't fault them." However, a relative told us they did have concerns that their relative would not get a good standard of if they did not visit regularly. The issues they raised were echoed in some of the complaints we saw about the service.

We arrived at the home at 9.30am on the first day of our inspection. Upon arrival the atmosphere was quiet and calm. We carried out a tour of the building in order to meet people and make observations. We saw that people had been supported to have a hot drink and many were in the process of eating their breakfast or had finished breakfast. People had been supported with their personal care and had been made comfortable.

Throughout the course of the inspection we observed the care provided by staff in order to try to understand people's experiences of care and to help us make judgements about this aspect of the service. We saw that staff were warm and respectful in their interactions with people and we saw they had a good rapport with people.

We saw that the care provided to people was very task orientated and staff told us they did not have any time to spend with people outside of providing direct 'hands on' care.

Staff told us they were clear about their roles and responsibilities to promote people's independence and respect their choice, privacy and dignity. They were able to explain how they did this. For example, when supporting people with personal care they ensured people's privacy was maintained by making sure doors and curtains were closed and by speaking to people throughout, by asking people's permission and by explaining the care they were providing.

However, we found that there was not always a clear consistency in how staff approached people because we saw an example of staff talking to each other over a person's head. We also heard a number of staff refer to people who required assistance to have their meals as 'feeders'.

We saw no references in people's care plans about the individual ways that people communicated and made their needs and wishes known. We also saw no evidence to indicate that people had been included in developing their care plan so they could play an active role in decisions about their care.

We saw from the staff training matrix that staff had not been provided with training in topics such as equality and diversity or person centred care.

We saw that signs had been put on people's bedroom walls with instructions for staff about their moving and transferring needs. We discussed this with the manager as this is not dignified for the people concerned. Staff should know people's needs without the information being posted on people's bedroom walls.

Inadequate

Is the service responsive?

Our findings

We received mixed feedback from people who lived at the home about the responsiveness of the service. People's comments included: "I can get up when I want to, [staff] comes and asks me if I need anything and shows an interest", "The staff keep me informed", "I am not happy with the service, there is nothing to do", "I get no support with my walker, they want me to stay in my room all the time. It is as if they can't be bothered" and "Staff have no time to chat, there are no activities, no entertainment and no choice."

Relatives also gave us mixed feedback. Their comments included: "They always keep us informed if there is anything", "They act quickly if they think there is something wrong" and "I would speak to the manager if I have any complaints which I do have."

We looked at a sample of pre-admission assessments for people who lived at the home. These are assessments that are carried out prior to people being admitted to the home. We saw these did not include important information about people's needs. The assessments were mostly a tick list and the level of detail in them would not be sufficient to form the basis of a person's care plan. We saw two examples where people had been admitted into the home with limited and conflicting information which had not been appropriately questioned or challenged by staff. This compromised people's care and welfare and in one case put the person as risk.

We also found that care was not planned appropriately. We viewed the care plans for five people who lived at the home. We found all five care plans were not sufficiently detailed to provide guidance for staff on how to meet people's needs. This was because much of the information in the care plans we viewed was about staff processes and not about the individual needs of the person. For example, a care plan about medication would refer to the need for staff to maintain accurate documentation or for a registered nurse to administer medication. It gave no indication as to what medication the person required, or why or how the person preferred to take their medicines. We saw that risks to people's safety or welfare had been assessed as part of their care plan. However, we did not always see corresponding information/care plans about how to support people to manage the risks. For example, a number of people were deemed to be at risk of developing pressure wounds but there was no guidance about how to prevent this as part of their care plan. Some care plans detailed that the person 'may need bedrails or 'may need a pressure mat'. This indicated that care plans were written generically and were not person centred.

We viewed the care plan for a person who had been admitted to the home recently. A temporary care plan had been in place for six days prior to a number of care plans being implemented with a variety of dates some of which were dated over a week after the person's admission. The temporary care plan was poor and included no significant information about the person or their needs. This was despite the person having been admitted with a number of serious illnesses. The temporary care plan was about processes and generic so could have referred to any one of the people who lived at the home. We also found there had been no base line assessments carried out upon the person's admission and their weight had not been checked or documented three weeks into their stay. One of the registered nurses told us it sometimes took up to four days after a person's admission to the home to start producing a care plan because they were so busy they did not have time to start them any quicker.

We looked at how people who had wounds were being supported. We found information about how to support people with wounds was not always in place or up to date and accurate. One person had a number of wounds. The only 'wound management' plan for this person was dated 2011. Recent pictures had been taken of their wounds but these were the only pictures on file so there had been no consistency in this practice. Records to detail the care and treatment provided to people's wounds were not being maintained appropriately and we saw significant gaps in records. We spoke with a permanent registered nurse and they were able to tell us about people's wound care. This information was different to the old information recorded on the wound plans. Nurses told us they did not have the time to keep on top of care planning and other records. The high use of agency and bank nurses means that it is crucial that this sort of information is up to date and accurate. On the first day of our inspection one floor of the home was staffed by an agency nurse who had been called in to cover staff sickness. They told us they had only been given a limited report about people's needs. We asked how they would know for example how much oxygen a person should be having. They told us they did not know where they would find the information. We found the agency

Is the service responsive?

nurse was not aware that one of the people who lived at the home was visually impaired. We heard a number of examples whereby this had not been communicated to agency nurses.

People who lived at the home who we spoke with did not know what a care plan was. We saw no evidence, in the care records we viewed, that people who lived at the home or their representatives had been consulted with about the contents of their care plan or to indicate that they were in agreement with it. We also noted that people's consent to matters such as the use of bed rails had not been attained.

Our findings demonstrated concerns with the quality of care planning and how information about people's needed were communicated across the staff team. People who lived at the home were at risk of not receiving the care and support they need if their care is not planned effectively.

We found that the registered person had not protected people against the risk of receiving inappropriate care and treatment through the effective assessment of needs and planning of care and treatment. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activities co-ordinator had been employed to work at the home since our last inspection of the service. People who lived at the home and staff told us there were still not enough activities and we saw no activities taking place throughout the three days of our visit. Staff told us that many of the activities were being provided on a one to one basis and therefore there was little impact for people in terms of the frequency of activities because there were 57 people living at the home.

The provider had a complaints procedure which included timescales for responding to complaints. We viewed the complaints' log and saw that complaints had been investigated and responded to. We viewed a number of lengthy complaints about the quality of the care provided at the home and some of the concerns raised where reflected in what we saw and heard about the service. This indicated to us that appropriate action was not being taken to ensure improvements were made following complaints.

Staff also told us they did not have confidence that complaints they raised would be dealt with appropriately and action taken as a result. We found a number of examples whereby there had been no learning from complaints and concerns. For example, concerns raised by outside professionals about poor record keeping and the provider not being able to demonstrate the care and support provided had not resulted in improvements to the service and the record keeping.

We found that the registered person had failed to prevent or reduce the impact of unsafe or inappropriate care or treatment through having an effective system in place to receive and respond to complaints. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings for people who lived at the home and their relatives were not being held on a regular basis. The last meeting was held in February 2015 and prior to this there was a meeting in September 2014. This had been the first one for some time. Surveys had been given to people who lived at the home and relatives for their feedback about the service. Some of the feedback in the surveys, particularly about the qualities of the staff team, were very positive. However, some of the feedback echoed some of the concerns we identified during the inspection. We saw that an action plan was in place to make improvements in response to people's feedback, however we saw little evidence that this been implemented to date.

Is the service well-led?

Our findings

The systems in place for assessing and monitoring the quality of the service and making improvements were ineffective. Improvements were not being made in response to feedback from people who lived at the home, relatives, staff and health and social care professionals.

We were concerned that the service was not learning from mistakes and not making changes to practice in response. We have cited a number of these under the safe domain. We saw numerous examples whereby recommendations from safeguarding investigations had not been implemented and as a result improvements to the service had not been made. We saw examples of the impact of this because the same concerns continued to present a risk to people who lived at the home.

We found that areas of practice were being audited. However, the findings of our inspection have shown that the audits have been ineffective in identifying shortfalls and in ensuring improvements were made. We have reported on the shortfalls we found under the other domains of safe, effective, caring and responsive.

We saw that the registered manager carried out audits on areas of practice such as: care planning, wound management, medicines management, falls, weights, infection control, catering and health and safety. However, we found the manager's audits failed to identify shortfalls in the service. An example of this was the medication audit. This failed to identify concerns with medication practices. The manager had scored the most recent medicines audit carried out on 24 February 2015 as 97% compliant. Another medicines audit carried out in October 2014 was scored at 100% compliant. However, during the course of our inspection we found serious concerns with the management of medicines. These had not been picked up in the manager's audits. We found that it was not possible to carry out an effective check on medicines because there were no stock control measures or appropriate accounting for medicines. Part of the medication audit asked 'Is there evidence that there is an efficient method of stock control in place' and this was ticked as 'yes' for compliant.

The most recent care plan audits consisted of a check of five care plans in November 2014 and four care plans in July 2014. We found the quality of information in care plans and other records relating to people's care was poor. If care plans had been audited effectively then these concerns should have been identified and rectified. The manager carried out six monthly health and safety audits with a recent score of 99.3 %. However, we found a number of shortfalls in health and safety related practices. The manager told us they carried out a monthly wound audit. We saw that the monthly wound audit had not taken place on four occasions between June 2014 and January 2015. We found that the wound audit for a person with a number of pressure wounds had not picked up that there was no up to date wound care plan and the one on file was four years old.

The running of the home was overseen by a management consultancy company. The 'registered person' for the service worked for the consultancy company. They told us they visited the home every two weeks and carried out a monthly audit. The monthly audit looked at the views of people living at the home, staffing numbers, staff views, complaints and safeguarding issues, staff disciplinary and human resources, the premises, clinical issues, record keeping, health and safety, infection control, staff training and supervision, food and dining experience, activities and visitors feedback. The registered person provided a report on their findings and an associated action plan and they shared these with us.

Both the audits being carried out by the manager and the registered person had not identified many of the concerns we found. For example, we found concerns with the pre admission process and pre admission assessments were poor. We found major concerns with the quality of care planning and the maintenance of records about the care and treatment provided to people. We also found concerns with wound management plans, medication practices, infection control, health and safety practices, staff supervision, staffing, safeguarding records, accident records and the quality of food.

We looked at accident reporting. We knew that one of the people who lived at the home had sustained an injury earlier this year for which they required attendance at hospital. We found there was no accident report for this. The registered manager was not able to offer an explanation as to why there was no accident report. This had not been picked up in either the manager's or the registered person's audits of the service.

The home was running with a high use of agency staff. This was particularly the case for registered nurses and carers

Is the service well-led?

covering nights. People who lived at the home were at risk of not receiving appropriate and safe care because there was a high use of agency staff and poor systems of communication in place. Whilst there had been some improvement to the number of permanent qualified nurses employed since our last inspection the home was still carrying a number of vacancies and a further registered nurse was working their notice at the time of our inspection. The compliance action we gave at our last inspection had therefore not been met as the provider was not employing sufficient numbers of suitable qualified, skilled and experienced staff to work at the home.

The majority of staff told us they did not feel well supported and they had no confidence to raise concerns with the manager. They also told us they felt when they raised matters they were not listened to and their requests/ concerns were not acted upon. Carers felt that the manager did not respond effectively or quickly enough to requests for equipment for people who lived at the home. This feedback was echoed in the results of a staff survey carried out in 2014. We saw that the provider had carried out an analysis of the staff surveys but we saw no evidence that they had taken action to address the concerns raised.

Staff told us they did not feel there was an 'open' or 'good' culture in the home and they described communication across the home as poor. Some of our findings confirmed this. Staff meetings were only being carried out sporadically. We saw some recent meeting had taken place but there had been lengthy gaps between meetings.

Staff told us they felt the turnover of staff was high and they felt this was as a result of staff feeling unsupported. Information about 'new starters' and 'leavers' confirmed that the turnover of staff was high. We found that of the 50 members of staff who had commenced employment over the past two years 31 of these had since left. Overall, there had been 56 members of staff left in two years including 16 registered nurses.

Registered nurses we spoke with told us they had raised concerns that there were not enough nurses working on shift and they were not able to keep up with the work required of them. They told us they had raised this concern with the manager and the registered person but nothing had been done to increase the level of nursing cover.

Lines of accountability across the home were not clear or understood by staff. We found there was a lack of accountability for a number of areas of practice.

We found that the registered person had not protected people against the risk of inappropriate or unsafe care and treatment by not having systems in place to identify and manage risks and to make improvements to the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 13(1)(2).**

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 registered person had not made appropriate arrangements to protect people who used the service against risks associated with unsafe management of medicines. Regulation 12 (1)(2)(g).**

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 registered person did not have effective systems in place to maintain appropriate standards of cleanliness and hygiene. Regulation 12 (1)(2)(h).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People were not fully protected against the risks associated with unsafe premises. Regulation 15 (1)(e).**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not made suitable arrangements to ensure staff were appropriately supported in their roles and responsibilities. Regulation 18 (2)(a).**

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 registered person had not taken proper steps to ensure that each person who used the service was protected against receiving care or treatment that is inappropriate through carrying out an appropriate assessment of people's needs and the effective planning and delivery of care. Regulation 12 (1)(2)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had not ensured people who used the service had a suitable choice of nutritious food in sufficient quantities. Regulation 14 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person did not have an effective system in place for receiving and responding appropriately to complaints. Regulation 16 (1).**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used the service were not protected from unsafe and inappropriate care as the registered provider did not have an effective system in place to regularly assess and monitor the quality of the service provided. Regulation 17 (1)(2)(a)(b)(c)(e)(f).

The enforcement action we took:
The provider was served with a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was required to comply with this notice by 31 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken appropriate steps to ensure that there were sufficient numbers of suitably qualified persons employed at the home to safeguard the welfare of people who lived at the home. Regulation 18 (1).

The enforcement action we took:
The provider was served with a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was required to comply with this notice by 31 May 2015.