Whisselwell Care Limited

The Priory Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We visited the home on 1 and 8 December 2016. The purpose of this inspection was to judge if the service had improved after a number of breaches of regulation were identified on two previous inspections in 2016.

Following our inspection in May 2016, we served two warning notices, relating to staffing and good governance. In August 2016, we re-visited the home due to concerns regarding people's safety and found the staffing warning notice had not been met. During our current inspection, we found a new breach and four on-going breaches of the Health and Social Care Act 2008 and associated Regulations and a new breach of the Act; this included the warning notices for staffing and good governance which still have not been fully met. The service was part of a whole home safeguarding process and was being visited by a range of health and social care professionals. They were also being supported by the local authority's quality assurance and improvement team.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The registered manager is also one of the directors of the registered provider. Throughout this report we have referred to the registered manager. There are also two deputy managers who the registered manager has delegated some managerial duties to.

The service lacked effective leadership and the management style was often reactive rather than proactive. There was not an effective system to regularly monitor and assess the quality of the service and the risks to the people living there. This meant improvement had not been made in some areas of care and new areas of concern had not been addressed or identified.

Previous inspections by CQC had highlighted concerns regarding staffing levels and the registered manager had not effectively monitored if staffing arrangements kept people safe and met people's physical and mental health needs. We identified concerns about staffing levels in the evening at this inspection. People did not always receive care at a time convenient for them and lacked adequate supervision in communal areas.

People were supported to see, when needed, health care professionals. Care staff recognised changes to people's physical well-being and knew to share this. However, some aspects of medication administration, storage and recording were poorly managed.

Safety checks were carried out but some areas of the home were potentially unsafe to people living with dementia. Aspects of infection control practice did not protect people from the risk of cross infection. The reporting of safeguarding issues by the management team had improved. However, some staff did not have the knowledge and confidence to identify safeguarding concerns and act on these to keep people safe.

Applications had been made for Deprivation of Liberty Safeguards (DoLS) assessments for people living at the home. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Discussions between the registered manager and deputy managers highlighted there was a lack of clarity whether the applications were appropriate for all of the people living in the home. However, people's consent for day to day care and treatment was sought by staff.

In one aspect of the recruitment process, there had been improvement to make it a safer process, but there were still gaps in recruitment information. This meant potentially people unsuitable to work with vulnerable people had not been identified. People living at the home were cared for by staff who had not been appropriately supported through induction and training. However, throughout our inspection we saw people were supported in a kind and caring manner by staff who knew them well. Staff spoke about people in a compassionate and caring manner. Staff showed a strong sense of loyalty towards the people living at the home. Most people said they felt safe and comfortable.

People were positive about the quality and range of food at the home. They said the food was well cooked and they enjoyed their meals. People were supported to ensure that they had enough food and fluid to support their health needs. However, recording was not consistent to help manage the risks to people's health.
There was an effective complaints system to address people's concerns. Activities to motivate people and promote a positive well-being were available, but there was not a system in place to ensure activities happened regularly to meet people's individual interests.

During the inspection we identified four continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider's failure to sustain full compliance since 2014. We have made these failings clear to the provider and they have had sufficient time to address them.

We are taking further action against this provider and will report on this when it is completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. Following the inspection, we shared our concerns with the local authority safeguarding team and commissioners.

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 was on-going poor management of staffing arrangements. Staffing levels in the evening did not support people's safety and well-being.

The reporting of safeguarding issues by the management team had improved. Some staff did not have the knowledge and confidence to identify safeguarding concerns and act on these promptly to keep people safe.

There had been improvement in one aspect of the recruitment process to make it a safer process but there were still gaps in recruitment information.

Some aspects of medication administration, storage and recording were poorly managed.

Infection control measures had not been assessed effectively and there were poor systems in place to manage the risk of cross infection.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff training and induction was not well managed, although systems were in place to formally monitor staff practice through supervisions and observation.

People's legal rights were protected as deprivation of liberty safeguard applications had been made. However, there was a lack of clarity within the management team about the appropriateness of all of the applications.

People were supported to see, when needed, health care professionals. Staff followed their advice.

People were supported to ensure that they had enough food and fluid to support their health needs. However, recording was not consistent to help manage the risks to people's health.

Is the service caring?

Good

The service was caring.

Staff did not rush people and reassured people as they supported them to move.

Staff talked with us about individuals in the home in a compassionate and caring way. Their practice showed they knew people as individuals and demonstrated a good knowledge of people's needs likes and dislikes.

Staff were considerate and caring in their manner with people and knew people's needs well. They were friendly and supportive when assisting people. They treated them with dignity and respect when helping with daily living tasks.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities to motivate people and promote a positive well-being took place but there was not a system in place to ensure they regularly met people's individual needs.

Staff listened to people's opinions and acted upon them. However, the staffing levels meant staff could not respond in a timely way in the evenings to people's needs.

There was a complaints system; people and a relative told us they had not needed to make a complaint since our last inspection. People made their views known if they were not happy with something. Staff responded quickly, offering reassurance and trying to resolve the problem to the person's satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

The service lacked effective leadership.

The registered manager, who was also the provider, had not ensured that there were effective systems in place to effectively monitor the quality and safety of the service provided and identify areas for further improvement.

The Priory Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We were also visiting to inspect the action taken by the provider to address enforcement action by the Care Quality Commission (CQC).

We have completed four comprehensive inspections and two focused inspections since a comprehensive inspection in December 2014. In a focused inspection in May 2015, we followed up on a previous warning notice relating to governance of the service; this had not been fully met. In a comprehensive inspection in May 2016, we found there had been improvements, although further work was needed to sustain and embed the changes. A further focussed inspection took place in August 2016, which was in relation to concerns raised about the quality of people's care and to check whether the service was compliant with enforcement action. On both of these inspections, the service had not improved enough to address the enforcement action.

We visited the home on 1 and 8 December 2016. The visit was unannounced and was carried out by one inspector on the first day and by one inspector and a pharmacist inspector on the second day. The service provides accommodation without nursing care and is registered for 21 people to live at the home. When we visited there were 12 people living at the home and one person staying there temporarily.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is

required to tell us about by law.

During the visit we met 13 people living at the home; five people shared their views on living at The Priory Residential Care Home. We spoke with one visitor to the home, seven staff and the registered manager who is also the provider. We contacted the district nursing team, visiting health and social care professionals, GPs and the local commissioning and contracting team, plus the local authority quality improvement team. Five health professionals and two social care professionals responded to our request for information. We also gained permission from visiting health and social care professionals to use information from their recent reports following visits to the home.

We observed care and support in communal areas and also looked at 12 people's bedrooms and two bathrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for three people, the training and induction records for three staff employed at the home, the recruitment files for three staff working at the home, training records for staff and 13 medication records. We also discussed the quality assurance audits systems with the registered manager and the deputy managers.

Inadequate

Is the service safe?

Our findings

Staffing arrangements at the home did not always maintain people's safety and well-being. In May 2016 CQC took enforcement action in relation to staffing arrangements at the home. We returned to the service in August 2016. We checked on the progress of the provider's action plan in order to confirm the provider had met their legal requirements to ensure there were suitable staffing arrangements in place. We also followed up on reports of concerns regarding the safety of people living at the home. We found there was a continued breach of the staffing regulation.

Following the inspection in August 2016, we received an action plan to address breaches of regulation, which included deploying additional staff in the early evening. As part of a whole home safeguarding process, the registered manager arranged for staff to send us staffing rotas each week for us to check people's needs were being met. Two people also moved out of the home. This was because the service could not meet their care needs. After they moved out, the registered manager took the decision to cancel the additional evening shift as they said feedback from staff was that additional staff were no longer needed. They had not used a staffing assessment tool or their own observations to help them assess if this feedback was correct.

On the first evening of 1 December 2016 we stayed at the home until 8.30pm. This was because we were concerned the staffing levels of two night staff from 7pm did not meet the care and emotional needs of all the people living at the home. Staff and the management team told us there were five people out of 13 people living at home that needed two members of staff to support them to move and to help with personal care. A sixth person had been assessed by staff as needing two staff members because of their mental health needs.

At 7pm, three of the six people who needed two staff to support them remained in the two lounges. After a handover between the day and night staff had finished, two night staff assisted one of the people to bed in a room on the first floor. The call bell in the front lounge had been left on the wall and out of reach of a person in a wheelchair and a person using a zimmer frame. Care records showed three of the five people in the two lounges had been assessed as high risk of falls. People said to each other "Are they coming now?", "Where is everybody tonight?" and "I'm stuck here." A person became very distressed for a period of over half an hour; they were unhappy and were crying.

A staff member from the day shift stayed on after 7pm to complete care records; they said they did not regularly stay late. The staff member from the day shift stayed for an additional 90 minutes; this was not planned but because they voluntarily chose to stay. There were five people left in the two lounges. If the staff member from the day shift had not stayed there would not have been a care staff member present on the ground floor. This was because the two night staff were assisting another person to bed.

The staff member from the day shift provided drinks for a person in the TV lounge and helped another person change into their nightclothes in a nearby bathroom so they could watch TV more comfortably. The care staff member from the day shift worked hard to reassure a person who was upset by the delay in staff

taking them to bed.

The following morning we contacted the registered manager with our concerns regarding staffing levels in the evening. They had received feedback from staff about the previous evening. They decided to change the timings of shifts to create an additional evening shift for a staff member from the activities team. There was a lack of clarity between the registered manager and the deputy managers whether this new shift was to finish at 8pm or 9pm. The registered manager said the additional hours had been put in place immediately and a new rota showed this shift. On the second day of our inspection, we met staff who were working on this new shift until 9pm. However, rotas for the week including Christmas Day showed on three days these arrangements were not in place.

On 16 December 2016, the deputy managers told us they had requested an additional staff member for day shifts after re-assessing people's care needs, which the registered manager had agreed. A rota for ten days later showed this increase was not consistently in place despite the deputy managers' assessment that staffing needed to be increased.

This is a continued breach of regulation 18 of the Health and Social Care (2008) Regulations 2014.

During the daytime, people's care needs were met and staff were attentive and responded to people's requests, including answering call bells. However, one person who spent time in their room said on two recent occasions, including the day we visited, staff had forgotten to make their bed. Another person said staff did not respond quickly to their call bell but printed records of response times showed their bell was answered promptly. People showed us their call bells or the pendants they wore to call staff.

Several people told us they felt safe. A person said "I have a bell to ring – they make sure I have this on all the time." They told us they felt safe and nobody came into their room uninvited. A health professional said they often heard call bells ringing for some time but this might be the time of day they visited. They confirmed people in their rooms had access to call bells. Another health professional said they had visited twice and the atmosphere was relaxed, organised and happy.

The home provided a day service for people living in their own homes; some people stayed into the early evening. Staff said this could mean up to three extra people during the day. They were supported by day care staff, who ran activities in the larger lounge and dining room. These staff also supported people living at the home, for example with their meals or with helping them to the toilet.

Two deputy managers worked at the home during the week, often supporting and supervising staff on the floor. At times, they also covered care shifts in an emergency or due to staff shortages. There was one senior and three care staff on duty from 7am until 7pm. Following feedback about staffing levels and roles after our inspection in May 2016, the shifts of the cook were split to cover lunchtimes and suppertime.

A cleaner worked five days a week. Care staff managed the laundry duties. The registered manager's hours were not logged on the staff rota. They said they usually visited the home at least twice a week but said their hours could be variable and they were available on the phone for support. Sometimes agency staff were used to cover shifts that could not be filled by a permanent staff member. A staff member said often agency staff had worked at the home before so knew the people they were supporting.

Since our last inspection in August 2016, there had been a number of changes in the care staff group with six new care staff joining the care team of 17 staff. Some of these changes followed concerns about staff practice, which led to formal disciplinary action. There had also been changes amongst the deputy

managers who supported the registered manager.

In May 2016, we judged people were not protected from the risk of abuse because there no written evidence to show appropriate actions had been taken to investigate incidents and reduce the risk of recurrence. Since the May 2016 inspection, there have been individual safeguarding investigations into the care of five people. Health and social care professionals expressed concern that the internal records completed by the management team and the response to a staff member's actions had not recognised the significant impact on one of the people living at the home. As a result they met with the management team and the person's advocate to ensure adequate steps had been taken to protect people living at the home. It was acknowledged that the abuse was reported immediately by a deputy manager when evidence of neglect was found and a staff member was disciplined.

At this inspection, we judged managing safeguarding concerns still needed further improvement. Some staff did not have the knowledge and confidence to identify safeguarding concerns and act on these to keep people safe. We spoke with care staff about their understanding of abuse and their role in protecting people. Several staff knew how to report various types of abuse and where to find contact details for external agencies. However, one staff member reported a concern made by a person living at the home about another staff member's practice, which had happened the day before. They had not yet reported the allegation to the registered manager or the deputy managers; we did this after speaking with them. The staff member had recently attended safeguarding training. Another staff member was also aware of the allegation but had not reported it either; they were due to attend safeguarding training. Following our inspection, a letter was sent to staff by the deputy managers to remind them to report allegations of abuse straight away.

People living at the home were not protected from abuse because there was not a thorough approach to the management of allegations and abuse by staff. During our inspection, a note in a staff member's file recorded they had neglected two residents. There was no record of this being discussed with the staff member and there was no record of how their practice would be monitored after the event. A deputy manager said they had met with the staff member involved, although their next supervision in October 2016 made no follow up comment about the concerns and whether their practice was monitored afterwards. However, another staff member involved in neglecting the two residents was dismissed.

Another staff member had their practice monitored over a range of shifts and tasks until the deputy managers were confident they could work to an appropriate standard but the concern had not been fully investigated. After another incident, a further formal disciplinary process was undertaken. A second staff member who was on shift with them had not reported what they had seen immediately. The registered manager acknowledged in a safeguarding meeting that they had not reviewed how the second staff member was supported with their understanding of safeguarding and their responsibilities.

This is a continued breach of regulation 13 of the Health and Social Care (2008) Regulations 2014.

We found a poorly completed incident report for one person who had complex mental health needs. The registered manager said safeguarding had been informed but there was no log this had happened or record of the advice that had been provided. The safeguarding team have confirmed to CQC they were satisfied with the action taken by staff to keep the person safe. The registered manager and the deputy managers have attended safeguarding training with the local authority. They told us training was planned for staff up until March 2017 in this topic.

In our August 2016 inspection, we were concerned by the number of incidents between people living at the

home. Staff said on this inspection there had been no significant incidents between people since several people had moved from the service. Records confirmed this. There was a record of a minor altercation between two people; a deputy manager recognised staff needed support in writing up incidents as they said the language did not accurately reflect what happened. One of the people living at the home needed additional monitoring because their behaviour could put others at risk. New staff could tell us about the person's care needs and how they supported them to feel involved in their care and the life of home, which we observed.

Following the dismissal of a staff member, the registered manager had not liaised with the Disclosure and Barring Service (DBS); this agency helps prevent unsuitable staff working with vulnerable people. They were reminded at a safeguarding meeting in November 2016 this would be best practice. During the meeting, we were told that the investigation was not complete as a statement from another member of staff was still missing, which had not been addressed by the registered manager. A referral to the DBS has now been made.

Safe recruitment procedures did not consistently ensure that people were supported by staff with an appropriate character. In our May 2016 inspection, we judged people were not protected because of poor recruitment procedures. The registered manager told us they had made improvements to their recruitment process. During this inspection, we saw that improvements had been made in ensuring there was a Disclosure and Barring Service (DBS) check in place before staff worked at the home. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

However, one staff file was missing one reference. The management team said this had previously been in the file. They rang the previous employer after day one of our inspection who sent a duplicate reference and confirmed the person was suitable to work with vulnerable people. We checked another person's staff file and found a gap in their employment history and that a job reference had not been sought from their most recent care employer. Instead a reference was sought from a person who had employed them two years previously. Lack of a full employment history and a lack of a current care reference could mean staff who had previously left care work because they were unsuitable for this role, could be employed without this information being known.

This is a continued breach of regulation 19 of the Health and Social Care (2008) Regulations 2014.

Following the inspection, the registered manager updated a recruitment check list to ensure staff were recruited safely.

Some aspects of risks to people's safety were not always effectively managed. Following our inspection, we contacted the registered manager with concerns regarding the temperature of hot water in the home, particularly in two bedrooms. Staff said there was not a risk to either person. Staff sent us the risk assessments for each person, which were not dated and did not reference the fact that the temperature of the hot water was high. One person had the ability to access the sink in their room. We asked for further reassurance that action had been taken to keep people safe.

Infection control measures had not been assessed effectively and there were poor systems in place to manage the risk of cross infection. For example, a staff member carried a commode pot containing urine across a hallway without a lid to empty it down the toilet in a communal bathroom. There was no cleaning fluid for them to use to clean the pot thoroughly and staff confirmed this was always the case. Observations of staff wearing gloves for different tasks indicated they did not understand the gloves' purpose or their

responsibility for reducing the risk of cross infection. For example, staff wore gloves after taking people's clothing to the laundry baskets but then still wore the same gloves to touch a door handle used by others. This was also the case when another staff member wore gloves to clean a commode pot and then touched a door handle still wearing the same gloves.

The service improvement plan showed the deputy managers had discussed with staff a plan to appoint a staff member to champion better infection control in the home. This was following advice from the local authority quality improvement team, who had highlighted their policy.

Some aspects of medication administration, storage and recording were poorly managed. The Medication Administration Record (MAR) charts showed records made on the MAR charts were incomplete. They did not show when all topical medicines (creams to help moisturise the skin or skin protective agents) were used for one person. For example, we saw that the records were only completed on 17 out of 30 days, while for a second person that they were only completed for 14 out of 30 days. Two people's medicine expiry dates had been incorrectly calculated and they were given their medicine after they had reached their expiry date.

Two people were given 'when required' meds without clear explanation of why or any evaluation of their effectiveness. Both the registered manager and a staff member told us that the entries on the MAR chart for one of these people were signatures to indicate that the medicine had been given. They then told us later in the inspection that this was incorrect and that the entries indicated that no medicine was available to administer. Staff confirmed there was not a list of staff signatures, which meant it was hard to track which staff had administered medicines.

We found that the medicines in use were stored securely within medicine trolleys. However the medicines storage cupboard and medicines fridge were not secure as the locks on these did not work. A staff member arranged for these to be repaired during the inspection.

These are breaches of regulation 12 of the Health and Social Care (2008) Regulations 2014.

Three people in the service had been assessed as needing thickened fluids to help prevent choking episodes when drinking fluids. Staff were able to describe how these were used and also able to identify which people needed to have them. We saw that the powders used to thicken the fluids were stored safely. Records of medicine training and observation of medicine administration of medicines were seen for three staff authorised to administer medicines.

Safety measures were in place keep people safe and reduce risks. For example, radiator covers and window restrictors had been fitted in people's bedrooms. Staff told us only one person had been assessed as needing a door alarm to alert staff if they left their room; records showed staff checked each night that it was working effectively.

Five out of nine armchairs in the TV lounge had stains on the arms. This was highlighted in our inspection in May 2016. The carpet in the main lounge had large dark marks on it; staff said it had been deep cleaned but this had not been successful in removing the marks.

There was a personal emergency evacuation plan file for staff to refer to in the event of a fire. Everyone living at the home, apart from one person had a plan in place. This was highlighted to the registered manager to rectify. The plans showed what support people needed in the event of a fire. Records showed there were regular checks of the fire alarm system. Staff confirmed fire training took place. Senior staff said they ensured agency staff knew the fire procedures when they arrived on their first shift.

Requires Improvement

Is the service effective?

Our findings

We inspected this service on 3 and 11 May 2016 following concerns about a number of issues including the safety and treatment of people. Improvement was needed to improve people's nutrition and hydration, the home's environment and staff training. Following the inspection, we received an action plan from the registered manager to show how they had addressed concerns.

The training and induction programme for new staff did not provide them with all skills/training needed for their role. New staff did not receive comprehensive induction and training. For example, new staff to care had not completed the Care Certificate despite the Provider Information Return stating it had been initiated. The Care Certificate is a nationally recognised set of standards that health and social care workers are expected to adhere to in their work. This would normally be completed in a 12 week period to enable new staff to absorb new information and develop their new skills. The induction training plan used at The Priory Residential Care Home was completed in one day despite it covering 57 different topics. The registered manager told us they believed the induction programme covered the best practice principles within the Care Certificate.

The registered manager said they were concentrating on new staff completing training which they viewed as mandatory. However, records for one new staff member, who had been in post for ten weeks showed they had completed only one training session provided by the Speech and Language team. A second new staff member who had been in post a similar amount of time had only received training in medicines. A third new staff member was praised by the deputy managers for being proactive in completing training workbooks. Staff told us they shadowed experienced staff to help them learn how to care for people; rotas showed this time varied.

On the reference for a new staff member, a previous employer suggested they would need further support to develop their understanding of dementia. This training had not been provided and was not logged in their supervision training plan. Many people living at the home were living with dementia and several people had complex mental health needs. However, staff training records showed only eight staff out of 22 had completed training in caring for people living with dementia.

Records showed some new staff had not completed practical training in how to move people in a safe manner. Staff were encouraged to complete a theory based training module but when we checked two out of three new staff members had not returned their completed work. No staff working at the home had a current train the trainer qualification in moving and handling as their qualification had expired. This meant staff who were judging new staff members' competence to move people safely did not have up to date training to do so. Following the first day of inspection, when we raised our concerns about this, the registered manager told us they had arranged for an external training company to deliver practical moving and handling training. During our two day inspection, we saw staff moved people safely, although some staff were more aware than others regarding the potential risks connected with foot plates on wheelchairs. The registered manager said poor practice was not acceptable and staff had been told to ensure footrests were in place before people were moved.

This is a continued breach of regulation 18 of the Health and Social Care (2008) Regulations 2014.

The induction for new staff included shadowing an experienced staff member, which rotas showed. Training records showed the majority of care staff had completed a nationally recognised qualification in health and social care to a Level 2 standard. Since the inspection, the registered manager has told us a number of staff were either working towards or have completed a level 3 or above in this type of qualification. Since the inspection, the registered manager told us that 'All new staff now complete the Care Certificate if they do not already have it and in addition we will do observations using the Care Certificate assessment on new staff who have completed the Care Certificate prior to starting at The Priory.'

Following feedback from visiting health professionals in November 2016, a member of the management team said they had worked on improving the standard of supervision and the level of detail recorded. They showed us an example of this change of approach, which was an improvement when compared to previous supervisions. Staff files showed supervision was being provided, which staff confirmed. The registered manager had delegated supervision of staff to their two deputies. Staff told us they felt well supported by the deputy managers. The deputy managers said they were struggling to fulfil supervisions as often as they would like because of other managerial responsibilities but said they were committed to providing it.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS). The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. As part of the whole home safeguarding process, it had been identified that there were delays in making applications for authorisations to deprive people of their liberty. Applications had recently been made to the local authority DoLS team for other people living at the home, who were awaiting assessment. This helped to ensure that people were not unlawfully restricted. However, discussions between the registered manager and deputy managers highlighted there was a lack of clarity whether the applications were appropriate for all of the people living in the home.

Staff asked people for their consent before they assisted them and checked with them that they had understood their request. For example, staff explained how they planned to a move a person and then talked them through the process when equipment was used. Conversations with two staff members showed training was required to help them understand how people's legal rights are protected by the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The training matrix did not include training in the MCA. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant.

The registered manager said there had been no recent best interest meetings for anyone currently living at the home. We queried whether a person at risk of falls at night because they did not call for help had the capacity to understand the risk. The registered manager and staff said they had not considered whether the person had the capacity to understand the risks or agree to the use of equipment, which would alert staff and might help reduce this risk. This meant an opportunity to consider what action to take in the person's best interest had not been considered.

Visiting health professionals praised the work of the deputies regarding the health and welfare decisions made on behalf of another person living at the home. This included recognition that the use of equipment to protect them might have conversely increased their risk of harm because of their medical condition.

However, they highlighted another person's bed rails were not suitably covered to protect them from the risk of entrapment, which staff addressed

Communication between staff coming on duty was effective. For example, we listened to a senior handing over to night staff. The standard of information was high and the senior highlighted risks re people's physical and mental well-being, including people's risk of pressure damage and food intake. During the inspection, care staff updated each other about where in the building they were working to support people. This was important because staff did not have a way of notifying each other where they were in the building apart from using the call bell system.

Food records showed there was a choice of meal but several people were unsure if they were always told the second choice for the lunchtime meal. However, they said they felt able to say if they did not like what food was on offer. Some people struggled to remember what was for lunch; the menu was not displayed as a reminder of the choices available. However, people were positive about the standard, portion size and taste of the meals served. They said "the food is very good", "lovely...homely cooking", "the food is good" and "very good, rather like home cooking." Care records detailed people's allergies and preferences, and staff practice showed they knew people well, including their food likes and dislikes.

A relative told us they now ate regularly at the home and they praised the standard of the meals served. Several people on a pureed diet were provided with the same meal at lunchtime and suppertime on occasions. This meant they were not provided with the same level of choice as other people living at the home. A visitor said they thought their relative could show through their physical response if they were not happy with this arrangement.

Visiting health professionals who reviewed care practice in the home on 21 and 22 November 2016 highlighted people's food and fluid intake was not recorded in a consistent manner. This meant there was an ineffective way of monitoring if people were eating and drinking enough to keep them well. We reviewed records of two people's food and fluid intake who were particularly vulnerable because of their complex health needs. There was still an inconsistent approach to recording how much they had eaten with gaps for some meals on the eight days following the health professionals' visit. This meant there was the potential for staff not to be responsive to changes in people's eating habits in a timely way to ensure people's weight was maintained.

We checked people's weights, which were generally stable, and for some people their weight was increasing. However, as with the food and fluid charts there were gaps in the records, which meant it was not a reliable way of monitoring people's health.

Since our last inspection in August 2016, action had been taken to improve the preparation of meals for people with swallowing difficulties. A staff member had not been using the appropriate equipment, and their work was supervised until the registered manager was confident with their practice. A number of staff had received recent training from a Speech and Language therapist, with a second session planned. A staff member said they had found this helpful because it had boosted their confidence in their preparation of thickened drinks. Staff were attentive when supporting people with their meals, checking if people wanted assistance and offering subtly to cut up items of food.

People told us they were comfortable. Staff checked with people if they were in pain and needed pain relief. They also asked other staff to monitor people's well-being and to check later if they were in pain. Records showed staff contacted health professionals for advice and to share information about changes to people's health. People told us they had been visited by health professionals, such as the dentist and district nurses.

A health professional said they had been asked to visit by a person's GP because the person had been experiencing pain. Despite a letter being sent with the appointment details, the health professional said staff were not expecting them and could not initially provide the information they needed to make their assessment. The health professional said a second staff member joined the assessment and was "a credit to the home" because they were helpful and looked through the care notes to help with the assessment. A second health professional said they visited on a monthly basis to provide foot care on a private basis. They said people looked well cared for, staff recognised if people needed treatment for their feet and contacted them appropriately.

A third health professional said referrals had been timely and staff were ready for their visits and up to date with their knowledge of the individual. However, another health professional reported their team could become frustrated that improvement in health care was not always sustained and staff needed prompting to maintain improvements. They recognised staff needed support to understand why the advice was given and to understand the impact on individuals if care staff did not follow their advice. They said they were working closely with staff at the home to ensure the advice they were given by health professionals was realistic and consistent. They had met with the management team at the home to create a good working relationship.

Health professionals reviewing if people living at the home were safe said that referrals were being made to relevant health care professionals. They reported a GP had praised how staff reacted to a person with deteriorating mental health.

Good

Is the service caring?

Our findings

Visiting health professionals had highlighted that night shifts were mostly staffed by male staff only. This did not provide people with a choice with regards to the gender of staff to help them with personal care, although no one we spoke with raised this as a concern. Since the inspection, the registered manager said one female staff member had been recruited for the night shifts and a further two female staff members were in the process of being recruited.

People's consent for day to day care and treatment was sought. Staff gained people's consent before they assisted people to move and they explained what they were doing and involved the person. Staff gave people eye contact and ensured they had their attention before they started to move them so they were not startled and to reduce their anxiety. Staff did not rush people and reassured people as they supported them to move.

A visiting health professional commented that a member of staff had "a fantastic relationship" with a person living at the home. The staff member's approach assisted them to complete their assessment and helped put the person at ease. A social care professional said staff were "kind and caring". They praised the "fantastic" attitude of one of the senior care staff saying their approach was "nurturing" towards people who needed additional reassurance and understanding. A person said The Priory Residential Care Home was "like a home, not firm, I feel relaxed." Another person said staff were "very pleasant" and "very kind." Several health professionals commented that staff knew people living at the home well. A visitor told us their relative was "extremely well looked after."

Staff listened to people's opinions and acted upon them. For example, where they wanted to spend their time. Staff supported people's friendships but also recognised when people needed time on their own to enjoy a particular television programme without interruption.

Each person was encouraged to personalise their room with things that were meaningful for them. For example, with photographs, and items of furniture and several people told us they were happy with their rooms and felt comfortable in them.

Staff talked with us about individuals in the home in a compassionate and caring way. Their practice showed they knew people as individuals and demonstrated a good knowledge of people's needs likes and dislikes. Care plans contained information about people's individual choices and preferences and contained brief personal histories. This enabled staff to have knowledge of people's past and people and events special to them. Some staff were skilled into tuning into people's changing moods and emotions. For example, a person became distressed by noise, which a staff member recognised and moved them to another area with their permission. The person said "that's much better."

Staff were considerate and caring in their manner with people and knew people's needs well. They were friendly and supportive when assisting people. Staff treated them with dignity and respect when helping with daily living tasks and maintained people's privacy and dignity. For example, they knocked on bedroom

doors before entering. In the dining room, staff were attentive and changed their approach to suit the different needs of people. They discretely checked with people if they needed assistance with their meals. This was also confirmed by a visiting health professional.

One person was worried about the cost of using a hairdresser that visited the home. Later in the day, a staff member offered to wash their hair. When the person returned to the lounge, their mood was more positive and it was apparent that they had benefited from one to one time with the staff member and felt better about their appearance. A health professional commented on the thoughtful approach of one particular staff member who took time to help people with their appearance and understood the importance of maintaining people's dignity. Other people living at the home were visited by an external hairdresser; staff took time to compliment them on their appearance, which people responded positively to.

Staff told us how they had considered how they could make the weekend feel different for people from other days of the week. They said their aim was for people to feel part of a social activity and have a different routine. A trolley had been introduced at suppertime with brightly coloured food to attract people. Food had been included that people could help themselves to and different types of cakes. Staff confirmed the trolley was taken around to people who chose to stay in their rooms. Staff said they sat with people as they ate and they commented that people seemed to relax and enjoy the occasion.

Since our last inspection, a compliment had been logged from a visitor to thank the staff and managers for the support they had given them and their relative during a difficult period.

Requires Improvement

Is the service responsive?

Our findings

We inspected this service on 3 and 11 May 2016 following concerns about a number of issues. We judged this key question to be requires improvement. Improvement was needed to improve to meet people's care needs in a timely manner and to update care plans to reflect people's current needs. Following the inspection, we received an action plan from the registered manager to show how they had addressed concerns.

Activities staff provided a range of activities, including at weekends. These included armchair exercises, craft work, dominoes, quizzes and singing sessions. People were invited to join in, although some said they chose not to. One person said what they liked about the home was "being left alone" and another said they just wanted "to relax." However, other people's mood and general well-being improved as they participated in group activities, shown by their smiling and laughter. We asked staff what they would improve and several said they would like people living at the home to have the opportunity to go out. They said this had declined in the last six months and rarely happened. They felt a number of people were bored.

People's records did not show how people individual interests were supported. Two people were mainly cared for in their rooms. One person had music on that their relative said they enjoyed; staff confirmed the person's musical preference. However, another person had the television left on, which was tuned into a programme that seemed unlikely to be their choice. They were not able to tell us their preference and from their body language seemed disengaged from the television programme.

Some people were at risk of developing pressure ulcers and a monthly risk assessment was completed to monitor for changes. One person's charts showed this had not happened for November 2016, although the previous five months had been completed. People had equipment in place to address this risk, including pressure relieving cushions and specialist mattresses. Some people had charts in place to record when they were moved by care staff to reduce the risk of pressure damage. In a handover, staff were updated on people's skin condition and reminded to apply prescribed creams and monitor their skin for changes.

During the day time staff were responsive to people's care needs. For example, we saw people being supported with their continence needs throughout our two day inspection. Staff were observant and recognised when people might need support to find the toilet and changed their approach depending on the individual to help maintain their dignity. Staff were busy but call bells were answered in a timely manner. However, staffing levels had not been responsive to people's individual needs in the evening of the first day of our inspection.

Work had taken place to update care records. This included an 'At a Glance' summary sheet which contained pertinent personal information about each person. People also had information on display in their room to provide a summary of their care needs. This helped new staff and agency staff be clear on how the person needed to be supported and the potential risks for them. We reviewed a sample of care plans, which reflected the care needs that staff described to us and our own observations. The registered manager had made the decision to transfer care records to an electronic system; they explained one of the aims was

to improve record completion by care staff. They described this as work in progress. We did not review these electronic records as staff told us they had not had time to transfer a complete care plan.

Staff working in the kitchen said there was good communication from care staff about how people had responded to meals. The cook was aware of their responsibility to monitor how well people were eating and whether a concern needed to be raised with senior staff or the management team.

During the inspection, one of the management team observed a person in the lounge and then contacted a health professional to advise them of a possible change to the person's behaviour, which could increase their risk of choking. They updated us on the health professional's advice and said they had also contacted the GP to update them. They had asked senior staff to monitor the person and reassess in the morning as to whether a GP visit was needed. This showed they were responsive to changes and potential increased risk for this individual. Another person had been assessed at risk of choking; staff told us how they must be positioned correctly at meal times, which reflected the information in their care plan.

There was a complaints system; people and a relative told us they had not needed to make a complaint since our last inspection. Staff said they would direct visitors making a complaint to the management team. During our inspection, we heard people making their views known if they were not happy with something. Staff responded quickly, offering reassurance and trying to resolve the problem to the person's satisfaction. Sometimes people living at the home complained about other people who lived at the home. Staff sensitively tried to manage the situation to maintain people's privacy while acknowledging other people's frustrations. The complaints log showed a complaint in July 2016 had been followed up by a deputy manager and resolved. We were told no further complaints had been received.

Inadequate

Is the service well-led?

Our findings

We inspected this service on 3 and 11 May 2016 following concerns about a number of issues. . We found that quality assurance systems had not always been fully completed. This meant risks to people's safety and well-being had not been acted upon or recognised. We took enforcement action to require the registered manager and provider to make improvements. On this inspection, we judged that a warning notice service earlier in the year to improve the management of the service had not been met. This meant there was a continued breach of the good governance regulation.

The registered manager had responsibility for running the home. They outlined that many day to day duties were delegated to two deputy managers, this included assessing people's suitability to move to the home, writing care plans and reviewing them. People living at the home and visitors to the home named the two deputy managers when they were asked who managed the home. The registered manager spent a minimum of two days a week at the home but they were available by telephone the rest of the time. Staff said they could contact the registered manager by phone.

The registered manager said they had increased the amount of time they spent at the home following the service being placed in a whole home safeguarding process in July 2016. As part of the safeguarding process, CQC asked for weekly rotas to be sent in advance so we could monitor the staffing levels at the home. These have not been routinely sent to us and we have had to request them on a number of occasions. Rotas did not record when the registered manager was working in the home but showed when the two deputy managers were on duty. Their hours were usually Monday and Friday, plus on occasions some additional shifts at weekends to check on staff practice or to cover staff sickness.

Deputy managers were not fully supported in their role, despite one being new in post. The registered manager had formally met with the deputy managers once since July 2016 to discuss how they would work together as a team to improve the service. There were no minutes of this meeting to show what had been agreed and who was responsible to carry out actions. One of the deputies had not been supervised by the registered manager since they had started in their role in July 2016. The other deputy had been supervised by the second deputy. The registered manager had not ensured an allegation of abuse was investigated thoroughly and recorded appropriately by staff who had been delegated this role. This meant there were not systems in place to ensure the deputy managers, who managed the day to day running of the home, had the appropriate skills, training and knowledge.

Communication and organisational procedures were at times weak and impacted on improving the service. For example, at a safeguarding meeting in November 2016, it was apparent that the registered manager and deputy managers had not been working on the same version of the action plan to improve the service. There was a lack of consultation regarding the implementation of a new electronic care system. The deputy managers were not using the system and further training for care staff had not yet been provided by the registered manager. The registered manager said this was planned. There was a two month delay by the registered manager in following health professionals' advice to make Deprivation of Liberty Safeguards applications. When this was highlighted by health professionals the deputy managers were then allocated

this work by the registered manager. During our inspection, the registered manager said they did not think all of the applications were necessary. This showed there was a lack of guidance and communication between the management team.

Risks identified by visiting health professionals were not always responded to in a timely way by the registered manager. On 5 October 2016, in a safeguarding meeting, health professionals who visited the home raised concern with the registered manager that one staff member was working excessive hours. This could potentially impact on the safety of people living at the home. On 30 November 2016, health professionals highlighted that the registered manager had not addressed this and the person was still working long hours. Two months after the original concern, the registered manager said a system had been created to monitor the hours of this staff member.

After two people moved out, the registered manager took the decision to cancel additional evening staff. They said this was based on feedback from staff covering the additional shift. However, they had not recorded how they assessed the dependency levels of other people living at the home to confirm this was the right decision. They increased the staffing levels following our feedback from day one of our inspection; this was a reactive response rather than proactively ensuring the emotional and physical care needs of people were being met.

The registered manager delegated the auditing of the safety of the building to other staff. In our May and August 2016 inspections, plus a previous inspection 2014, we had highlighted to the registered manager that poorly completed audits had not insured people living at the home were safe. This related to the safety of the environment, checking hot water temperatures and the safety of equipment.

Following our inspection, we contacted the registered manager with concerns regarding the temperature of hot water in the home. We highlighted a recent audit which showed several rooms, which were occupied, had hot water temperatures that were higher than recommended by the Health and Safety Executive. On the audit these rooms were ticked to show no action was needed. There was no guidance on the form to ensure staff knew what temperatures were considered as appropriate. Ten days after we raised our initial concern we were advised by a deputy manager that the hot water temperatures were all within the recommended level following action by the handyperson. The registered manager had not adequately monitored that infection control procedures and some aspects of medicine management needed improvement.

Some parts of the home had maintenance issues which had not been addressed. For example, staff said one room did not have a window that opened as it had been painted and become stuck. In another room, we noticed the window was missing secondary glazing to help keep the room warm. Staff explained the secondary glazing in this room had become a hazard to people's safety but had not been replaced. Secondary glazing in a second room had also been identified as needing replacing, which staff said the registered manager was aware of. This meant that people were at increased risk because systems for undertaking routine repairs and maintenance and maintain safety were not adequate.

The registered manager said part of their role was to ensure training was updated and recorded. The training schedule had not been maintained accurately and some staff training was not up to date. The registered manager said they usually audited the recruitment files every three – four months. Their audits had not identified the areas of improvement that were needed in their recruitment processes. One of the roles of the registered manager was to audit the records of people's falls and to check what steps had been taken to reduce the risk. The registered manager last completed this audit in June 2016, although they said a deputy manager checked them monthly.

The registered manager shared with us a medicines policy which they were in the process of updating but we found that this did not reflect the practices carried out in the service and needed to be tailored to reflect the service. Visiting health professionals had advised the registered manager their safeguarding policy needed updating, which they were working on when we inspected.

The registered manager sent us a copy of their infection control policy. It was not specific to the home and did not provide practical guidance to staff regarding the disposal of the contents of people's commodes to help reduce the risk of cross infection. The service improvement plan stated that the registered manager was working on the service's statement of purpose, which had been highlighted by the local authority's quality improvement team as a policy to review and update. This team have visited the service on three occasions in 2016 to help the registered manager and their management team in connection to leadership and management arrangements at the service to help them work effectively. A report from the local authority's quality improvement team stated for some management tasks there was a lack of clarity over which member of the management team was responsible.

This is an ongoing breach of regulation 17 of the Health and Social Care (2008) Regulations 2014.

During our inspection, we acknowledged that the registered manager and deputy managers were working hard to make improvements, which had led to increased working hours for them. They all told us they wanted to make improvements to the service. An example of this is notifying CQC regarding events in the home; this meant a previous breach had been met.

Following the inspection, the registered manager told us how they managed day to day communication with their deputies, including hand over meetings for updates on the well-being of people living at the home and the use of management communication books. Since the inspection, the registered manager said the electronic care system was used routinely which enabled them and the deputy managers to monitor the running of the home and access records when they were not based at the home. Records showed the testing for electrical appliances was up to date.

The deputy managers said their commitment was to people's welfare and well-being. Following feedback from visiting health and social care professionals and their own judgement, the deputy managers had focussed on improving staff practice. This was through observation and working alongside them, and then checking changes and improvements were sustained. They said this and other work delegated by the registered manager had impacted on the completion of other managerial work.

The deputy managers were aware of the gaps in care records, such as recording people's food and fluid intake; this had been fed back by visiting health professionals. They expressed frustration that some areas of work such as the completion of care records were not being routinely completed by all staff despite staff being told in a meeting 'charts are just as important as care plans.' They said this was despite their oversight and explanation in team meetings why this needed to be improved and maintained. They were not able to give an explanation as to why staff were not consistently completing records. Two days before our inspection a checklist had been introduced to ensure records were completed at the end of each shift. In the service improvement plan it states they will carry out spot checks to ensure records improve.

Staff meetings had been changed to the evening to enable more staff to attend; deputy managers said the expectation was staff should attend unless there was a legitimate reason not to. The registered manager attended some of them. One of the deputy managers said they were trying to encourage staff to participate more in the meetings, such as how to improve the new electronic system, and to report concerns. They said their aim was for meetings to happen more regularly. For example, one took place on 27 October 2016

completed and another took place on the second day of our inspection on 8 December 2016. Following the inspection, the registered manager told us there were regular staff meetings with a clear agenda, and minutes are provided to all staff who were unable to attend.

The deputy manager said staff annual appraisals were being arranged and surveys had been sent out to relatives, staff and people living at the home. They said the surveys were now more in depth and a volunteer was going to support people with completing the surveys if they needed support.

Three staff praised the teamwork amongst care staff and other staff members saying there was "a good team" and "we really work as a team." One person said "I love this home." Staff praised the support they got from the deputy managers. Comments included "I can't speak highly enough of them"; one staff member praised the newest deputy manager in post describing them as "fantastic." Staff appreciated the deputy managers spending more time on the floor working alongside them and providing advice and guidance. Staff said if they shared concerns with the deputy managers that "things got done." Staff described them as "really approachable." However, some staff said they did not feel their loyalty and working extra hours was always recognised by all of the management team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some aspects of medicines, infection control and hot water temperatures put people at the risk of potential harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People living at the home were not protected from abuse because there was poor management of how allegations and abuse by staff were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment procedures did not consistently ensure that people were supported by staff with the appropriate experience and character.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not an effective system to regularly monitor and assess the quality of the service and the risks to people living at the service.

The enforcement action we took:

We served a warning notice with a timescale of 30 September 2016. The warning notice had not been met when we inspected in December 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's emotional and physical care needs at all times. Some staff had not completed training to ensure they had the skills and knowledge required to meet people's needs.

The enforcement action we took:

We served a warning notice with a timescale of 29 July 2016. The warning notice had not been met when we inspected in August 2016 and December 2016.