Barchester Healthcare Homes Limited

Wykeham House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 26 and 30 August 2016. Wykeham House is a purpose built care home providing nursing and residential care for up to 76 older people, some of whom are living with dementia. The service is separated into four units; two of the units are for people living with early to late dementia and the other two units are for people with greater nursing needs. At the time of our inspection there were 74 people living at the service.

There was a registered manager in post and present on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There was insufficient numbers of care staff deployed at the service to meet people's needs. This resulted in people waiting for their care and for their meals.

Fire evacuation arrangements for people were not in place and there were risks to people in the environment that were not being managed well. However there were other aspects of the risks to people that were addressed by staff.

Medicines were not managed safely and there was a risk that people did not receive their medicines when they needed. Staff competencies with medicines was not being assessed.

Staff had not received appropriate clinical supervision that ensured the most appropriate clinical care was provided. However other staff were having one to one support with their manager that promoted their development. We found the staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

Staff were not knowledgeable about current guidance to support people to make decisions. Where people had restrictions placed on them there was not always evidence that these were done in their best interests or necessary. Staff did not always have a clear understanding of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) or their responsibilities in respect of this.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. However people were not always given choices of meals. The recording of what people ate and drank was not always being undertaken. People were supported to have access to healthcare services and were involved in the regular monitoring of their health.

There were times where staff did not treat people with kindness, dignity and respect. However people's preferences, likes and dislikes had been taken into consideration and support was provided in accordance

with people's wishes. People's privacy was respected and promoted when personal care was undertaken.

People's needs were assessed when they entered the service and on a continuous basis to reflect changes in their needs. However care plans were not always updated with the changes to care.

Concerns and complaints were not always responded to appropriately and people did not always feel listened to.

The provider did not always have systems in place to regularly assess and monitor the quality of the care provided and to make improvements as a result. There were continued breaches from the previous inspection around the competencies of staff and people's care plans not being updated that had still not been addressed.

Although the provider actively sought, encouraged and supported people's involvement this was not always used to improve the quality of care. People's records were not always up to date or accurate.

People told us they were safe at the service. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

Recruitment practices were safe and relevant checks had been completed before staff started work.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the service. Staff told us they would report any concerns to their manager. Staff felt that management were very supportive.

We found several breaches of regulations. You can see what action was taken at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not administered, stored and disposed of safely.

There were not enough staff at the service to support people's needs.

People were not always protected from environmental risks. However people did have risk assessments based on their individual care and support needs.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their assessed need.

Staff did not always understand how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their health however on occasion there had been delays in contacting health care professionals.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. However people were not always offered choices around meals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. However we did see occasions where staff were kind and attentive.

On the whole staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people's needs were assessed when they entered the home and on a continuous basis the care plans were not updated to reflect the changes. There was not always detailed information regarding people's treatment, care and support.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the service and outside.

People were encouraged to voice their concerns or complaints about the service however people and relatives did not always feel their complaints were responded to.

Is the service well-led?

Inadequate

The service was not always well-led.

The provider did not always have systems in place to regularly assess and monitor the quality of the service the home provided. The provider had not met breaches in regulation from the previous inspection.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home but did not use this to improve the quality of care.

People and visitors said that the management was not always visible.

Staff were encouraged to contribute to the improvement of the service and staff would report any concerns to their manager.

CareQuality Commission

Wykeham House

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 26 and 30 August 2016. The inspection team consisted of four inspectors, an expert by experience in care 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 service) and a pharmacy specialist.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Instead we reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. We also spoke with one social care professional before the inspection.

During the visit we spoke with the registered manager, 11 people, two relatives and nine members of staff. We looked at a sample of seven care records of people who used the service, medicine administration records and supervision and one to one records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. After the inspection we spoke with two health care professionals.

The last inspection was on the 25 and 30 June 2015 where breaches were identified around the competencies of staff and care planning.

Requires Improvement

Is the service safe?

Our findings

Without exception people and relatives told us that there were not enough staff at the service. Comments included, "The staffing is much worse at weekends", "(The family member) has to wait a long time to use the bedpan as there are no staff available", "Staffing levels are an issue", "I think there could be more staff, it can take quite a while for everyone to get up, (their family) gets up quite late", "Sometimes they do seem short staffed."

There were not enough staff to meet people's needs. When we arrived at the service staff were busy providing personal care to people in their rooms. Morning personal care was still continuing for people at 11.30 and staff were being taken from other floors to assist. Where it was a person's choice to have breakfast in bed before they are assisted with personal care this was accommodated by staff so they may be helped to get up later. Comments from staff included, "It's stretched, it's hard when you've got to see all the people", "The have recently cut my floor down to two carers and it's not enough, you can't wash everybody before lunch", "There should be three staff am and pm but we are regularly short, usually when staff ring in sick, we do our best but we don't have time to sit and chat with people." When we asked what impact the lack of staff had on people one member of staff said, "People might not be able to shower and we have to give them a strip wash instead." Whilst another said, "I want to do the best for the residents but we can't always; some roll over for us when they need a bedpan (indicating this could be done with one carer) but others just have to wait until two carers are free." During lunch people sitting in the dining rooms were waiting long periods of time before they were provided with their lunch. This was because staff were supporting people in their rooms to eat. On one unit people sat at their tables for 45 minutes before they were served their meals.

The registered manager told us that they used a service dependency tool to help determine the numbers of staff needed. They said that on one unit they were using one more carer during the day than the tool suggested and on another unit one less carer than the tool suggested. They told us that 11 carers were required in the morning and 10 in the afternoon. The rotas that we were provided with were also difficult to review but we could see that on occasions there were less than the required numbers of staff (as assessed by the registered manager). The registered manager said that they did struggle to fill the gaps of staff calling in sick; we saw that there was a lot of staff sickness at the service. One health care professional told us that they had noticed the staffing levels were difficult and that they could see that staff were stressed because of this. They said that there were people at the service who had very complex needs but had not seen the numbers of staff increase to deal with their needs. The accidents and incidents folder contained a number of unwitnessed falls; that could have demonstrated that staff numbers were not high enough to ensure that people were kept safe.

The lack of staff to support people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of unsafe care. During the inspection there were several occasions where people (who were able to use them) did not have access to their call bell. One person's call bell had fallen under their bed and another person's call bell had fallen behind the head of their bed. A

further person's call bell had been ringing for several hours as there had been a fault with the bell however this person now had no other way of attracting staff attention. One relative told us, "The call bells are ringing for long periods of time but if the carers are in the lounge the volume of the TV drowns out the sound of the call bell and it cannot be heard." We asked one person (whose call bell was out of reach) how they would attract the staff attention and they told us, "If the call bell is not in reach then I just call out" They said that this would usually get staff attention.

There were other aspects to the service that did not promote safe care. The environment was not always clean. In the lounge areas the chairs and carpets were stained with food debris and fluid and were in need of deep cleaning or replacing. Equipment stored in the bathrooms was dusty. The sluice room on one of the units had been left unlocked for most of the day which meant that people could access it, which posed a potential risk as cleaning fluids were stored there. People did not have their own individual slings when they needed hoisting which mean there was a risk of cross contamination. After the inspection the registered manager informed us that individual slings had now been ordered for people. In the event of an emergency such as a fire each person had a personal evacuation plan. However these were not personalised with information for staff on how people needed to be supported by staff in the event of an emergency. The registered manager told us that this was being addressed.

Accidents and incidents were not always responded to appropriately. Incidents were documented but actions taken to prevent an incident happening again were not recorded. Between May 2016 and July 2016, 13 incidents were recorded in which the page to record actions taken was left blank. One person suffered unwitnessed injuries twice within two months; on both occasions no actions were documented as having been taken to keep the person safe.

There was a risk that people were not always receiving their medicine. There were several incidents with people where the doses of medicines left for people did not match the amounts that the nurse had given them from the original prescription. The medicine audits that had taken place had not identified these gaps. There were occasions where the nurse had left the person with their medicine and had not observed the medicine being taken. One person was on an inhaler, according to a member of staff on occasion the inhaler was left with the person to take and this written on their Medicine Administration Record (MAR) as having been taken. 120 asthma doses were signed for from the pharmacy and nurses recorded that 51 had been given to this person which should have left 69 doses in stock. However, the automatic counter on the asthma device recorded 75 doses left. Another person had been prescribed treatment for their ears however staff did not start giving the person the treatment until three days after it had been prescribed. One person did at times refuse their medicines but staff were not following the guidance provided in the care plan to try and offer the medicine two to three times before recording this as refused.

There was a risk that people may not receive the correct medicines. On opening the medicines trolley we saw that medicines were stored in separate trays with the names and room numbers on the front however these room numbers did not correspond to the room numbers in the MAR chart folder.

People's medicines were not managed in a safe way. The review of the stock found one medicine in use had been marked as opened and in use since December 2014 and other liquid medicines did not have opening dates. A member of staff confirmed that this would not be expected practice and a new stock should have been obtained. One relative told us that the lids for the creams for their family member were always being left off and we found this on several occasions during the inspection. After the inspection the registered manager informed us that all stocks of out of date medicines including creams had been disposed of.

A member of staff confirmed that yearly medicine competency assessment should be undertaken. We

looked at a sample of these assessments and found that three nurse's competency assessments had expired in July 2015 and four nurse's competency assessment had expired in June 2015. Competency assessments were in the process of being re-done however the clinical lead had signed off chunks of the assessments leaving large areas blank including receipt, storage and administration.

The lack of safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other risks to people that were being managed safely. Risks were assessed in relation to people's nutrition, mobility and skin integrity and risk management care plans in place to minimise or eliminate risks. The care plans identified the potential risks to people and gave instructions and guidelines to staff in order to manage those risks. Equipment was provided to the person to reduce the risk of injury. This included walking frames, hoists and wheelchairs. Staff had knowledge of people's risks and we saw plans being put into action on the day of the inspection.

People were not worried about how staff would treat them and relatives did not have any concerns about how staff would treat their family members. One relative said, "I do feel mum is safe here, if there are any problems staff are here to help her." Staff had knowledge of safeguarding adults procedures, the types of abuse that could occur and what to do if they suspected any type of abuse. One staff member told us, "First I would approach a nurse or tell a manager. If I still wasn't happy I'd go to the whistleblowing policy." Another staff member told us, "I'd go to a nurse, if they weren't involved in it. If not I would ring the whistleblowing line."
There was a safeguarding adults policy and staff had received training in safeguarding people.

People were protected from being cared for by unsuitable staff because robust recruitment processes were in place. There was an up-to-date record of nurse's professional registration. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. Notes from interviews with applicants were retained on file and showed that the provider had set out to employ the most suitable staff for the roles. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not demonstrated the appropriate clinical skills to effectively deliver care. On this inspection although staff had received clinical training there were no formal assessments of their clinical knowledge. Clinical staff had failed to identify that someone was at risk of harm from a potential infection and failed to seek medical opinion for someone following a fall.

People and relatives were often but not always complimentary about the effectiveness of staff. One person told us that when they first moved into the service they were unable to walk. They said that with the care they received they were now able to walk independently. Another person said, "The staff are absolutely brilliant, If I could give them a medal every day I would" and a relative said, "Everyone to cleaners and the head chef are impressive." However another relative said they did not feel that staff responded quickly enough to identify when their family member became ill and to seek medical attention.

Despite the positive comments there were concerns that not all staff were suitably qualified, skilled and experienced to meet people's needs. Although nurses were up to date with their clinical training we did not always see good practice on the day. One person had a catheter bag which had a very strong odour and was discoloured. None of the staff we spoke to including clinical staff understood the reasons why this was happening. On the day of the inspection the registered manager had asked a nursing specialist (from Barchester) to visit. This nurse was instantly able to identify the reasons for the odour and the discolouration. Once advice was given to staff by this nurse the issue was addressed. There was no evidence that staff had sought guidance or advice prior to this despite staff telling us that it had been like that for several weeks. On another occasion there had been a delay of nearly 24 hours before a GP had been contacted about a person's head injury, despite the fact that the person had a diagnosis of epilepsy.

Nurses had not received the appropriate support that promoted their professional development. There was a clinical lead at the service. We asked to look at the clinical supervisions that the clinical lead had undertaken with the nurses. We were provided with some evidence of one to one discussion but these centred mainly on the nurses knowledge of MCA and safeguarding. The registered manager told us that clinical supervisions had not been taking place and that, "The nurses are not getting guidance and leadership." One health care professional told us that the nurses had not been as proactive as they could be with people's health needs to prevent them from being admitted to hospital. There had been an increased amount of people being admitted to hospital for conditions that could have been prevented. One health care professional told us that they had concerns about the competencies of the nurses. A relative told that staff did not always pick up on things quickly enough and that their default was to ask the relative if an ambulance should be called if they had concerns about the person.

We reviewed the supervision records for other staff at the service. The one to one supervisions mainly consisted of 'topic' discussions and staff were questioned on their knowledge of how to provide care under certain scenarios. However there was no written record of how staff had answered the questions put to

them or whether they had any additional training needs as a result. We looked at the supervision records for four newer members of staff and there was no evidence that their practices had been observed since starting at the service. The one to ones that took place for staff did not give them an opportunity to discuss their development needs or any additional support that they needed.

The lack of suitably qualified, skilled and experienced staff and the lack of staff support was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some good practice by staff on the day particularly in relation to how people were moved, infection control and food hygiene. Staff were up to date with the mandatory training and were complimentary about the training they received. Comments included, "We talk at supervision about the well-being of residents, how we can improve and training" (although this was not evidenced in the discussions and records) and "They do very good training here, I deliver some of the training here now." One health care professional told us that considering the needs of people that lived there staff cared well for them.

People's rights were not always protected because staff did not always act in accordance with the Mental Capacity Act 2005 (MCA). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. There was conflicting information in the care plans around whether people had capacity to make decisions. In one care plan the MCA assessment stated the person had the capacity to maintain their own personal care, safety and hygiene needs. However later on in the care plan it stated that the person lacked total capacity and that the person was completely dependent on their family to make decisions. There was no evidence of a best interest meeting around this. Another person had a 'Do not Resuscitate' form on their care plan however the care plan stated that the person wanted to be resuscitated. There was no evidence why it was in the person's best interest for them not to be resuscitated, who this was discussed with and why they had gone against the wishes of the person. The registered manager informed us after the inspection that the 'Do not Resuscitate' form had been removed. On the day of the inspection the registered manager provided us with the folder containing MCAs however this did not contain assessments around all of the decisions that needed to be made. Best interest decisions did not always detail why it was in the person's best interest to have (for example) a bed rail.

Staff knowledge around MCA varied, one member of staff said, "(Without assessment) we must treat them as if they have full capacity. If they don't have capacity to make a decision I still give options and choices and try to help them. I'd speak to family and look at their history." Whilst another member of staff said, "If they can make a decision for themselves or if they make an unwise decision you try to persuade them it's in their best interests to do something different." Nurses did not have sufficient knowledge around the MCA and told us that it was left to the registered manager to assess people's capacity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We noted that DoLS applications had been completed to the local authority for people living at the home. However these applications were not always supported with the appropriate mental capacity assessments. The registered manager told us that DoLS had been submitted for everyone that lived on the locked unit; however some of the people were able to use the access codes of the units and were free to come and go as they pleased. This meant that the DoLS would not have been necessary.

The failure to follow the legal requirements in relation to consent was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment did not always meet the individual needs of people living with dementia at the service. There were not enough areas of interest or sensory items for people to keep them occupied or engaged. We did see that there was signage on the doors to help guide people if they needed to use the bathroom and some people had memory boxes outside of their rooms to assist them. The lounge areas were well lit and people were able to walk around where they wanted. The registered manager told us that they had intentions to improve the environment for people living with dementia.

We recommend that the registered provider improves the environment to assist people living with dementia.

People told us that they enjoyed the food. Comments included, "The food is good; it's the sort of things I would choose, if there is anything special I would like they try and do it for me" and, "The chef caters for me and supports me to eat healthy meals."

We observed lunch being served in the dining rooms in each unit. Lunch menus were on the table for people however for those people living with dementia these were not in pictorial format. The chef told us that people who were on soft or pureed meals would also be offered a choice however we found this was not happening on the day of the inspection. One person (not on a soft diet) was given a meal; they said to the member of staff, "I don't like this." The member of staff replied, "Oh, it's my favourite" without acknowledging the person's statement. No alternative meal was offered. In other parts of the service we did see people being offered an alternative if they did not want what was being offered and there was extra soup or pudding offered to people who did not eat all of their meals. Some people had to wait up to 45 minutes at the dining tables for staff to support them to eat and lunch did not finish until just before 14.00. The evening meal started to be served three hours after lunch which meant there was a risk that people were being offered meals that they were not hungry for.

People were provided with equipment to help them eat and drink independently and nutritional assessments were carried out as part of the initial assessment when people moved into the service. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

We recommend that the registered provider ensures people are offered a choice of meals regardless of their dietary requirement.

People's care records showed relevant health and social care professionals were involved with their care. One person told us that they were able to access the GP and the physiotherapist when they needed and we saw evidence of this. Records showed involvement of GP, community nurses, Tissue Viability Nurse, dietician, Speech And Language Therapist (SALT) and the local hospice. One health care professional told us that staff always followed the guidance that they gave.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that there were caring staff at the service. Comments from them included, "Staff are caring, they are fantastic and very calm", "The carers are marvellous, they put up with so much", "Most of the staff will have a laugh with you and will listen to you", "They care for you and they're (staff) happy" and, "You really can't fault them, it's nice in here."

However, we found that people did not always receive attentive care from staff. There were moments during the inspection where staff were not as attentive to people's needs as they could have been. When an activity started in the dementia unit the people who had been watching the television were left sitting facing it rather than turned towards the member of staff who was playing the piano. On another occasion one person who was distressed came to sit next to us in the lounge. They were crying and saying, "Please take me out of this place." Staff did not intervene for some time apart from to offer them a drink. When we moved to a different seat much later and the person followed us staff did ask them if they would like to help make some beds which calmed the person down. On a third occasion a person was calling out from their room. Staff were seen to walk past the room and it was only after 20 minutes that a member of staff did go and see to the person.

People were not always treated with dignity and respect. People's appearance was not always maintained. Some men appeared not to have had a shave for several days and staff did not know why this was and there were people whose hair looked greasy and unkempt. We noticed that a lot of women not wearing bras. We asked the registered manager about this who could not tell us why this was or whether it was people's preferences. One gentleman still had his lunch around his face at tea time.

The failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were times where staff showed concern for people's wellbeing in a caring and meaningful way. One person was moving into a different room. Staff said, "Would you like some help with that." When the person agreed staff supported them to stand and move to the lounge in a gentle and reassuring way. At times staff spent time with people individually and chatted with people. Staff offered drinks and checked people were not too hot. At lunchtime one person liked to unfasten the carer's aprons and staff engaged with this and shared the joke. Staff encouraged people to sing along to the music whilst they were waiting for lunch and it was clear that from interactions that there were staff that knew people well. Despite the time pressures staff were seen to be interacting with people and enquiring as to how they were.

Staff told us that they enjoyed working at the service and understood how to communicate with people. One said, "I find the work really rewarding, making a difference to people's lives." One person who wished to speak with us could not do so verbally however staff supported this person using hand signs that they understood to help them communicate with us.

There was evidence in people's care plans that people and relatives (where appropriate) were involved in

the planning and making choices about their care. People and relatives that we spoke with confirmed this. There was information about how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference for male of female carers. However there was no detail around people's personal backgrounds that would assist staff to make connections or initiate meaningful conversation with people living with dementia. The registered manager told us that work was being undertaken to review people's care plans and update this information.

People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People told us that they were encouraged to bring things into the service that were important to them. Each room was homely and individual to the people who lived there.

Relatives and friends were encouraged to visit and maintain relationships with people. One person said, "I can have visitors at any time, it's no problem." One relative told us that they were always welcomed at the service. We saw visitors welcomed throughout the day of the inspection. People confirmed that they were able to practice their religious beliefs. We saw that religious services were held in the home and these were open to those who wished to attend.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection the service was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always receiving care that was appropriate to their needs. On this inspection we still had concerns that the improvements had not been made to meet the regulation and provide responsive care.

We asked people and relatives whether responsive care was provided by the staff. One relative said (in response to a change in their family member's needs), "They have made the necessary changes and staff are coping with things reasonably well." A person told us, "I now receive care in bed and the home have adapted to that really well."

Despite these comments there was a risk staff may not have the most up to date and appropriate information available to them for people. Where a need had been identified there was not always guidance or a detailed care plan for staff to follow. People who were insulin dependent diabetics had no care plan for staff about the signs to look out for and what they should do should the person become unwell. One person had a history of mental health related illnesses however there a lack of guidance for staff on how best to support them with this.

Information in people's care plans did not always reflect the care that they should be receiving. One person was supported to get up each day however their care plan stated that they were cared for in bed permanently. The care plan also stated that the person had pressure sores but the member of staff on duty said that these had cleared up very soon after they had moved in. The registered manager told us that they had just started to identify the lack of accurate information and guidance in the care plans. The lack of a personalised and accurate plan of care is a potential risk as staff may fail to deliver the most appropriate care to meet individual's current needs.

Information about people's care was not always shared between staff which put people at risk. On the first day of the inspection changes to the catheter care for one person had been identified. However on the second day of the inspection (three days later) this information had not been shared with staff and had not been written in the person's care plan. A relative said that communication with staff was not good. They had notified a member of staff that their family member had not opened their bowels for several days and that this needed attention. The relative said that they had raised this a few days prior to the inspection. The member of staff on duty had only been notified of this on the day of the inspection and again there was no record on the care plan that the person needed more fibrous food or other treatment to help them with this. Meetings between senior staff took place each week that discussed people's needs however there was no evidence that matters discussed were followed up and care or care plans updated.

The lack of care and treatment provided to meet people's individual and most current needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see other care plans that were detailed around the guidance staff needed to provide care. One

person had a significant health condition and there were detailed instructions on how the person needed to be cared for which staff were following. Another person had epilepsy. There was a clear plan in place that staff were following to manage the risks as well as written strategies to assist the person if they had a seizure. Other people's care plans had a description of their medical history, moving and handling, skin care and sleep routine and how people needed and wanted to be supported.

People confirmed that there activities for them to take part in if they wished to. One person told us, "I'm not able to get to everything on offer but they do try, they come and do my nails for me." Another person told us that they were able to go outside when they wanted and said that they took part in a lot of the activities.

There was a board displaying activities which included films, exercises, ball games, easy listening, hairdresser and aromatherapy. The activity coordinator encouraged people to participate and we heard people singing along. The activity coordinator did spend some time one to one with people. One member of staff said, "There is a budget we can use for things like the summer fete and dog Olympics. We try to create events that involve children as much as possible as the residents love them." There were seasonal events held at the service including summer fetes, Halloween and Christmas events.

There was a complaints procedure available to people. There were mixed responses from people and relatives as to whether they felt their concerns and complaints were responded to. Comments included, "I am happy with things but if I did need to complain I would go to the carers who would go to the seniors who would sort it out, they would all listen", "There was an on-going situation from an issue (raised some months ago), I had a meeting with the manager but I have not had anything in writing and I was not happy with the (verbal) response." Another relative told us that they had raised a concern with the manager that they did not feel had been resolved in a timely way or to their satisfaction. We reviewed the complaints folder and saw that although there was a record of a meeting with a person or relative there was no letter to inform them of how the complaint had been resolved. On some of the complaints it stated that staff had been addressed regarding these complaints however there was no record of this on the member of staff's file.

The failure to always investigate complaints and take the necessary action was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

On our previous inspection in June 2015 we had identified a breach around the competencies of the clinical staff and appropriate care planning. The provider sent us an action plan in September 2015 that stated that the competencies of the clinical staff would be undertaken and that care plans would be updated to reflect the needs of people. We found on this inspection that these areas had not improved sufficiently. Although the provider provided us with an action plan about how the clinical oversight of the service will be managed this should have been acted upon since the last inspection and before this inspection, particularly as the registered manager was aware of the clinical concerns.

There were aspects of the quality assurance that were not effective and had not identified the shortfalls in quality that we found on the day. In April, June and July 2016 a quality assurance visit was undertaken by the provider's regional team. None of the audits identified the lack of staff on duty, the lack of clinical oversight or the lack of MCAs and best interest meetings. However they had identified the lack of supervisions, the lack of updated information on care plans and that people who were living with dementia were not always being shown a visual choice of their meals. Despite this these areas had still not shown sufficient improvement as they continued to be a concern at our inspection.

On the first day of our inspection we asked the registered manager to advise us of any concerns they had where they felt improvements were needed. They told us that their main challenge was improvements with the nursing team and that things still needed, "to be done." However they gave us no further detail until we raised our concerns with them over the clinical oversight of the nurses and they confirmed they had concerns about this too. They also failed to tell us that there was a lack of clinical supervisions taking place which had been identified by us and the provider's regional team. On the second day of the inspection the registered manager did tell us that the nurses were not getting guidance and leadership and following the inspection the registered manager provided us with an action plan to address the shortfalls identified. This included the support from a nurse specialist from Barchester.

We saw that reflective practice sessions took place with the nursing team but they were not always effective. Discussions were around whether external medical intervention had been called upon soon enough when incidents occurred. There was no other evidence of any discussions with the nursing team around their clinical knowledge or their confidence in dealing with emergencies. Accidents and incidents were analysed and on 13 occasions between July 2016 and August 2016 there were unwitnessed falls with several people. Where referrals to the falls team (or other health care professionals) was appropriate this was done but there was no recognition that the increased amount of unwitnessed falls could be as result of how staff were deployed or whether there were enough staff on duty.

Records at the service were not always kept up to date and accurate. On one incident form it stated that the GP had been called out on the day of the incident. However a member of staff confirmed to us that this was not correct and that the GP had not been called out until the next day. Topical cream charts were not always completed when the needed to be and there were gaps in people's food fluid and repositioning charts. These gaps in records meant that people were at potential risk of not receiving safe care and treatment

because staff were unable to effectively monitor people's health and well-being, or that a prescribed medicine had been given. Where people needed to have their food and fluid recorded this was not always completed accurately as there were gaps in the recording over some days. Where fluid needed to be recorded there was not always information for staff around how much the person needed to drink. If people at risk of dehydration or malnutrition did stop eating and drinking enough this may not have been recognised soon enough to prevent risk to people.

Relatives confirmed they attended meetings and were involved in how the service was run. However the outcome of these meetings was not always used to improve the quality of care. At the March 2016 meeting we noted that one relative had asked for a change to the lunch menu on a Friday when both meal options were fish and another relative has suggested a later evening meal time. We found at our inspection that neither of these suggestions had been listened to and addressed.

The lack of effective clinical governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Various other audits were being used to improve the quality of care. As a result of these audits there were action plans detailing the comprehensive maintenance taking place around the service. This included the replacement of furniture and redecoration. Audits also addressed other areas. For example, fire risk assessments had been updated, additional mandatory training had been provided and infection control equipment had been replaced.

After the inspection the registered manager provided us with an action plan to address the shortfalls that we had identified. Trackers had been implemented to identify what staff required supervisions and when these were going to take place. A deep clean had been arranged to clean all areas of the service to include carpets and furnishings and an audit of care plans had been arranged. They had assured us that they were involving external health care professionals to assist with the clinical support for staff to help prevent hospital admissions where appropriate. .

We asked people about the manager of the service. Comments included, "If I had any problems I could just go to (the manager)", "(The manager) does come round and see us sometimes", "We always see the manager and staff in the office" and "I don't normally see the manager but the reception is usually manned."

We asked staff about how valued they felt at the service. One member of staff said, "We see the managers walking around; they listen to us and give us new ideas." Another member of staff said, "We have team meetings as a whole about every two months" and said that they were asked their opinion on how the service should be run. We confirmed that meetings did take place with staff and discussions took place around policies, training and staff sickness. There was an 'Employee of the Month' to celebrate the good work that took place. There was also recognition for staff who had achieved their care certificate and one member of staff had been nominated for the Barchester Care Awards.

The registered manager was aware of the requirements of their registration with the Care Quality Commission. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed the CQC appropriately.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided that met people's individual and most current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always treated with dignity and respect and that people always treated people in a caring way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's consent had been gained and their capacity had been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Receiving and acting on complaints The provider had not ensured that complaints were investigated with the necessary action taken.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service

The enforcement action we took:

.As this is a breach we issued a warning notice to the registered provider on the 15 September 2016 relation to Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were enough staff that were suitably qualified, skilled and experienced at the service.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 15 September 2016 in relation to Regulation 18