Walmley Care Home Ltd

Marian House Nursing Home

Inspection report

32 Walmley Ash Road
Walmley
Sutton Coldfield
West Midlands
B76 1JA

Tel: 01212408000
Website: www.marianhouse.co.uk

Date of inspection visit:
20 July 2016
21 July 2016

Date of publication:
28 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 July 2016 and was unannounced. The service is a care home that provides personal care and accommodation for up to 42 older people. There were 39 people using the service at the time of our inspection. There was a registered manager in place. 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.

We last inspected this service in July 2013 and found no concerns. We identified concerns at this inspection in relation to staffing, which included recruitment processes, training, deployment and staff interaction with people who used the service. We identified concerns with the leadership and culture of the service and found that people were not always protected by processes and safe staff practice.

Although staff had received guidance in relation to safeguarding processes, they did not always protect people from harm. Risks were not always managed effectively to help people maintain their health and a high number of incidents had occurred at the home, which records showed had not been analysed for themes or trends to learn from and to prevent further incidents.

People received their medicine safely, yet they did not always receive their medicines in a way that maintained their dignity. Although audits had identified some inaccurate medicines recording, this issue had not been rectified and put people at risk of not receiving their medicines as prescribed. Records showed that staff had not received training or updated guidance in relation to medicine administration.

Feedback showed that there had not always been enough staff to meet people's basic needs at all times and our observations confirmed this. People were not always protected by safe staff recruitment practices. Records were not robust to support the running of the service or to assist in keeping people safe.

Staff had not received all training for their roles and our observations confirmed that they were not consistently equipped with the knowledge and skills to meet people's needs. Where some staff were aware of appropriate and safe practices, they failed to consistently apply these to protect people from harm.

The service did not act in line with the principles of the Mental Capacity Act. Some people were restricted by staff practices at times and we saw that this caused them distress. People were not always supported to make decisions and their consent and choices were not consistently sought or respected.

People did not always have access to sufficient nutrition and hydration to help them to stay safe and well and healthcare professionals had raised concerns about this. There were ineffective processes in place to ensure that people were always supported by competent staff in a way that reflected their needs, or that concerns that people had not eaten were recognised or addressed.

Most relatives told us that staff met people's needs, yet feedback suggested that this was inconsistent and we saw that some staff did not understand people's needs. People had access to healthcare support as required for their needs and healthcare professionals told us that staff referred people promptly for support.

Staff were not consistently caring and failed to develop meaningful relationships with people and involve them in their care. Staff did not consistently express compassion or concern for people and did not always seek to act on their wishes. There were not robust systems in place to ensure that staff were aware of people's interests and preferences. Staff failed to consistently treat people with dignity and respect.

Care was not always responsive to all people's needs in a way that enabled them to have a good quality of life. Care plan reviews were not always completed in a timely way or to ensure that care reflected people's needs and preferences. There was a complaints process in place, yet concerns were not always dealt with openly and had not been used to drive improvement in the service.

We identified concerns with leadership of the home. There was a failure to maintain oversight of the service or effectively resolve concerns to ensure that people were always kept safe and always supported by staff who were competent and respectful. Processes at the home were not robust to protect people and ensure that their needs were met.

People's feedback was not consistently acted on in an open way and the registered provider and registered manager had not always acted transparently or fulfilled the requirements of their role. Staff were not always set clear direction in their roles and concerns in relation to the culture of the service and approach of staff were not addressed. The registered manager was not always approachable and feedback suggested that this had reflected into staff practice.

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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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 safe.

People's risks were not always managed effectively and people were put at risk of harm due to inappropriate staff conduct.

People's needs were not met by sufficient numbers of staff.

People were not protected by safe recruitment processes.

The medicines management at the home was not always suitable.

Is the service effective?

Inadequate

The service was not effective.

People were not sufficiently supported to eat and remain hydrated.

People's needs were not always met by staff who knew them well.

People's choices were not always respected and the service did not support people in line with the principles of the Mental Capacity Act.

Staff did not receive all of the training they needed for their roles.

People were supported to access healthcare support.

Is the service caring?

Inadequate

The service was not caring.

People were not supported by consistently caring staff.

People were not consistently treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care planning and delivery was not always person-centred.

People's complaints were not always dealt with openly and transparently.

Is the service well-led?

Inadequate

The service was not well-led.

People were not supported in an open and person-centred environment.

The registered provider and registered manager did not fulfil all requirements of their registration role.

Staff were not directed in their roles in a way that ensured that people's needs were met.

Records and audits were not robust to protect people and consistently meet their needs.

Marian House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 20 and 21 July 2016 and was unannounced. The inspection was conducted by an inspector, an expert-by-experience and a specialist advisor. The expert-by-experience's area of expertise related to dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a nurse with experience of managing nursing and residential settings for people living with dementia and for people with behaviours that challenge.

As part of our inspection, we looked at the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Although this had been requested, they did not return a PIR and we took this into account when we made the judgements in this report.

During our inspection we spoke with 10 people who used the service and 13 relatives. We spoke with 10 members of staff, the clinical manager, the registered manager and seven healthcare professionals. We carried out observations of how people were supported throughout the day and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We also looked at eight people's care records, four staff files and at records maintained by the home about risk management, staffing, training and the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Staff did not always protect people from harm or take the necessary action to keep them safe. Some safeguarding incidents had occurred at the home where people had been put at harm due to staff conduct and the registered manager informed us that safeguarding alerts and other action had been taken in relation to these. During our inspection, we observed unsafe moving and handling practice by staff, which caused a person to cry out in distress. We alerted the registered manager and clinical manager to this immediately who addressed this with staff and ensured that the person was settled. We later established however that being supported to move through unsafe practice was an ongoing risk to people. Records showed that similar incidents had occurred previously and one staff member demonstrated that they understood unsafe practice to be an appropriate way to support a person to move.

People's behaviours were not always investigated or managed and staff were not supported to effectively help people to become calm. We found this had put people and staff at harm. One person had experienced avoidable ill health as registered nurses had failed to respond to their symptoms in a timely way. Records showed that a high number of accidents had occurred at the home and that their prevalence had increased over time and while many of the injuries these caused were minor, no recognition had been given to the impact that repeated occurrences could cause harm to people using the service. Records showed that accidents had not been analysed for trends or themes for learning from and preventing future accidents across the service. The registered manager informed us that a fragility risk assessment had been introduced for people who frequently experienced falls and they provided us with examples of support people had received in line with these assessments.

Where measures were in place to manage one person's risk, we saw that staff had not consistently followed healthcare professional guidance to continue to manage their risk effectively and records showed that there were delays in this person receiving timely support as required, with a delay of four hours and forty minutes on one occasion, and seven hours on another occasion. On one occasion, the clinical manager had reminded staff about the importance of using specific products to prevent harm to people who had a particular risk. Records were not robust to support the running of the service or to assist in keeping people safe. A staff member told us that one person's support needs had changed and that they required less support, however guidance in this person's care plan confirmed that the staff member's understanding of the person's support needs was incorrect.

One person told us that they were able to take their own medicines and that they were pleased to do so. A relative had complained that one person had not received their medicines as prescribed and we saw that this complaint had not been addressed or investigated, however another relative told us, "Medicines management is absolutely fine, I have no concerns." This meant that where they required support, people were not consistently supported to receive their medicines safely. We saw that people were supported to take their medicines safely, however they were not always supported to do so in a way that maintained their dignity. For example, we observed staff interrupting two people's meals to administer their medicines while they were trying to eat their food with people in the dining room, without seeking their consent beforehand. On one of these occasions, the staff member told the person that they needed to take their medicines and

interrupted their pudding to administer their eye drops. The registered manager told us that staff had received supervision in relation to medicines practice and one staff member told us, "I have had training and if I had a concern or a problem I would be able to go and talk to the senior nurses." However, some medicines guidance for staff was outdated by almost five years and records showed that staff had not received medicines training. Medicines records were not always completed consistently or appropriately to reflect that people had been supported to take their medicines as prescribed. Although audits of medicines records had identified discrepancies, this had not been effectively addressed and we identified that one nurse had made 93 records errors alone over six months yet the clinical manager had failed to resolve this. Medicines records were not robust and this had put people at risk of not receiving their medicines as prescribed, this had not been resolved.

Failure to provide safe care and treatment to people and maintain safe medicines management is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff responded promptly to people's buzzers and one person told us, "I feel safe, the staff are very nice and they come when I call my buzzer, sometimes at night they are very busy and they take a long time to come." People did not always have access to their buzzers however where they were able to use these, so that they were always enabled to request staff assistance as required. Most feedback from people and relatives we spoke with reflected that staff were not always available to meet people's personal care needs in a timely way. Although the registered manager told us that they had increased staffing levels since our last inspection in 2013 and introduced systems for monitoring staffing levels at the home, the registered manager demonstrated that they had been aware of staffing issues yet had not taken steps to rectify or monitor these effectively. One person told us, "They are short staffed and it sometimes takes 20 minutes [for staff] to come when I call them." Relatives had raised concerns about the lack of staff presence in communal areas and that people's personal care needs were not always met in a timely way or as required. Records we reviewed and one person we spoke with confirmed that this issue had not been resolved and told us, "They have a strict method in the morning and you have to wait your turn… There are not enough staff on at night," and added that they did not receive personal care that reflected their needs as a result. One relative told us, "There are not enough staff, everyone would probably say that… Some care staff don't turn up and they can't always get agency, it depends [which staff] are on as to whether they cope… the really good [staff] cope with the numbers but there are generally not enough staff." One staff member told us, "Sometimes we are short of staff if someone is sick and we use agency." We observed that people were frequently left unattended in communal areas and a visitor confirmed, "There are not always [staff] in the lounge."

Staff were not always effectively deployed so that they could respond promptly to people's needs and support them safely. One relative told us, "A couple of times we have gone in and [my relative] is still in bed and not cleaned, I'm not sure how staff prioritise." On one occasion, a person expressed that they were in pain yet staff told this person that they needed to finish their meal before they could be supported to move, staff were not deployed effectively to do so. Records showed that staff had supported another person to move in a way that had put them at risk of harm, our discussions with the registered manager revealed that they had done so due to poor staff deployment. We found that the registered manager had not promptly acted to review staffing levels to ensure that people's basic care needs would always be met. For example, a healthcare professional told us that they had made recommendations to the registered manager to manage a risk to people and support them to remain well. The healthcare professional told us that the registered manager had implied that it was not possible to fulfil this support due to staffing levels, because staff had reported that they did not have the time do so. We raised our concerns with the registered manager about the lack of staff interaction we observed during our inspection and they told us that that it was not possible for staff to spend all of their time reassuring people. Staff meeting records showed that the registered manager had been aware of occasions where people's personal care needs had not been met in line with

their wishes, however prompt action had not been taken to resolve this.

Failure to ensure that there are sufficient staff that are suitably deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by robust and safe recruitment practices. The registered provider and manager had failed to consistently complete appropriate checks through the Disclosure and Barring Service (DBS) in advance of staff commencing their roles. Three staff files we checked for staff who had worked at the service for a longer period of time, showed that DBS checks and suitable reference checks had not been completed before staff commenced employment. We saw that another staff member who had informally commenced employment at the home on the day of our inspection had completed a DBS check beforehand and did not work unsupervised.

Maintenance checks and tasks were completed, however there was not a robust process to identify when maintenance tasks had not been fulfilled in a timely way. We raised this with the registered manager who told us they would address this. There was equipment in place at the home to support people to manage their risks and one nurse we spoke with could tell us some people's needs and how these were managed. The nurse showed us where they accessed emergency medicines to support people with symptoms.

Relatives we spoke with told us they felt that their relative was safe at the home. One relative told us, "Safe, yes, [staff] seem to be concerned for [my relative]." Staff had received some guidance in relation to safeguarding processes. Staff we spoke with were aware of some types of abuse that people were at risk of and told us they felt able to raise any concerns with the home management. We saw that staff had been reminded of safeguarding processes at a staff meeting, and people and relatives had been informed of the home's response in relation to a safeguarding incident.

Inadequate

Is the service effective?

Our findings

One nurse told us, "We have (monthly) supervision from the clinical manager," and added that they covered a different topic each month, including food hygiene and infection control. While some staff told us they had received training in dementia care, records showed that not all staff had received training for their roles, including training in safeguarding, Mental Capacity Act (MCA) and the nutritional needs of people using the service. The registered manager told us that they were only contractually obliged to provide one aspect of training. The registered manager added that they tried to strive for best practice and supply sufficient training for staff to do their roles safely and that processes were in place for staff to support one another. Our observations confirmed that staff were not consistently equipped with the knowledge, skills and ability to meet people's needs. While systems were in place at the service to develop staff awareness, these were not effective in ensuring that staff consistently reflected or demonstrated an understanding of people's needs and how to meet these.

A nurse told us, "If I need advice I just ask." Although staff we spoke with told us that they had received an induction and training, we found that this was not effective to equip staff and ensure that care always safely met people's needs. One staff member told us that they had received a good induction which had included moving and handling training early on. However, this staff member demonstrated that they had learned a way to support people to move which was unsafe and harmful to people. The staff member indicated that this was an appropriate way to support people to move and another staff member told us that they recognised this practice as abuse. We saw a reference to the Care Certificate in another staff member's file we reviewed, which is a set of minimum care standards that new care staff must cover as part of their induction process, however, records indicated that this staff member had not been supported to complete a full induction.

When we asked the registered manager to intervene and assist one person to become calm, we found that they led staff in delivering an ineffective approach which did not meet or identify with this person's needs or demonstrate empathy towards them. Staff were not equipped through care plans or leadership to appropriately support people who displayed behaviours that challenged. One person's care plan provided generic guidance about how staff could meet their needs and we saw that this had a detrimental impact on their care. Records showed that one staff member had requested further support from the registered manager about how to help another person to manage their behaviours, yet this had not been effectively addressed.

Discussions with the home management revealed that where staff had been trained and were able to demonstrate to the registered manager that they understood safe practice to support people to move, they did not always apply this in practice to protect people from harm. One record showed that the registered manager had previously queried a staff member's reason for their unsafe moving and handling practice and that the staff member had provided an arbitrary and irrelevant reason for providing this unsafe care. This meant that we could not be assured that people were always supported to have their needs met safely by staff who followed guidance.

Failure to ensure that staff are competent, skilled and receive training as necessary to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Most people who used the service had a DoLS application or approval in place, however staff failed to support people in line with the principles of the Mental Capacity Act. Some people were restricted from moving freely at times. One person said, "Please. Please I can't get up," and we saw that they had been supported into a position that restricted their movement. We raised this with the registered manager who told us they would investigate this issue further. Another person had been left wearing a lap strap after they had been supported to move which was not necessary for keeping them safe. The registered manager confirmed that the person should not have continued to wear this and told us that this would be removed. Not all restrictions in place were effective and maintained consistently by staff. Care plans did not direct staff as to people's abilities to make certain decisions and we observed that people were not often supported to make choices. Staff we spoke with had some understanding of the MCA, however we observed occasions where staff failed to seek people's consent, or ignored their choices before supporting them. One person struggled to understand the choices a staff member was giving them for their meal. We asked if they were able to assist the person further so that they could understand the options yet the staff member told us, "No, the ones that don't understand have their meal chosen for them."

Failure to seek or obtain the consent of people who use the service is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional and hydration needs were not always promptly met to keep them safe and well. One healthcare professional told us that staff regularly assessed residents for malnutrition and had requested prescriptions for nutritional supplements on a regular basis, without supporting people to eat extra fortified meals and snacks throughout the day and evening as required to help maintain their strength. Another healthcare professional told us that they had needed to stress the importance to the home of ensuring that people were always provided with appropriate nutritional support, before this was done to help keep people well. The home management told us they had made improvements to this aspect of people's care and records showed that audits were conducted to monitor the weight of people using the service.

One relative told us, "They don't give enough drinks… to ensure that people are properly hydrated… Carers who know [my relative] will persevere with food and drink… sometimes when [my relative] refuses, it sometimes feel like [staff] don't try as hard as they could." We saw that people were not consistently supported to drink in a way that met their needs to remain hydrated. One relative had complained that their relative had not been supported to access drinks over four hours and that staff had failed to recognise that the way they were supported failed to meet their needs by enabling them to access drinks. One person's care records referred to their breakfast and read, 'Spat out, would not open mouth,' which suggested that this person was not supported to eat in a way that met their needs. We saw that people who had not eaten their meals were not often encouraged to do so. This meant that staff were not always equipped to support

people to eat in a way that met their needs and had not acted on concerns where people had not eaten. One relative had complained that their relative had not had their evening meal on the previous day and that they had needed to prompt staff to supply food to them promptly and that this food was of poor quality. We saw that this complaint had not been logged as an official complaint or investigated.

People's care records did not consistently provide guidance as to how to meet their dietary requirements or to monitor people's ongoing risks. No effort was made to ensure that mealtimes were a pleasant experience for most people. We saw that some people who required encouragement to eat were patiently supported to do so by some staff that kindly persevered, however this was not consistent practice and we observed one staff member rushing a person by putting food in their mouth quickly and tipping their drink too fast into their mouth. Some staff were not aware of foods people had been given and we observed occasions where staff talked amongst themselves as they supported people to eat. For example, one staff member said to another staff member, "It's quiet isn't it? I've got a bit [of food] down [person], not a lot though." Whilst we noted that this staff member addressed the person using the service in a kind way shortly afterwards, it was not appropriate for the staff member to talk about the person in this way in their presence or the presence of other people using the service. This meant that people were not consistently supported by staff who supported them to access or enjoy nutritious meals that met their needs.

Failure to meet the nutritional and hydration needs of people who use the service is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most relatives we spoke with told us that staff met people's needs, yet feedback suggested that this was inconsistent. One relative told us, "They have got to be looking after my relative okay, there are no signs of deterioration and they are obviously caring for [them]." Another relative told us, "They look after my relative and their needs. [Staff] know them very well… Staff do what they are supposed to do." The home management told us that they required the use of agency staff as a last resort on occasions. One relative told us, "They use too many agency staff that are not actually qualified. They don't know what they're doing, or how to use [specific equipment], the normal carers obviously know and know what not to do… but others turn up and don't know what they're doing." Staff meeting records we reviewed showed that some staff shared this relative's view and had previously raised this with the registered manager and clinical manager.

Records showed that staff sought the support of healthcare professionals when required and one person told us, "I have the dentist visit me, they come regularly and I have seen the chiropodist regularly." One healthcare professional told us that the documentation at the home for a particular risk was "Normally good," and added that staff promptly referred people who required additional support and managed this risk appropriately. Another healthcare professional confirmed that staff had promptly referred people for support and told us, "Staff always seem to be on the ball."

Inadequate

Is the service caring?

Our findings

Relatives had mixed views as to whether staff were caring and our observations confirmed that while some staff were caring towards people, this practice was intuitive rather than guided and was not consistent amongst the wider staff group. One relative told us, "I'm very satisfied, the staff are caring, they're lovely people and the nurses are fine." Another relative told us, "The majority of staff are pretty good and will do more without being asked, whereas some staff will just look at it [an issue] and carry on." Another relative told us, "I'm happy with the way [my relative] is looked after there on the whole. Some staff are 'lazy' and it is only a job to them. When the good staff are there it's fine, and there are quite a lot of good ones, you know which ones they are." One person told us, "Some carers are good and some aren't." Visitors to the service were asked to complete annual surveys relating to their views and experience of the home. We saw that a survey conducted in July 2015 found that at that time the majority of people who responded stated that the friendliness and overall attitude of staff was 'good' or 'excellent'.

Staff failed to develop meaningful relationships with people. We saw staff often focused on completing tasks without interacting with the people they were supporting. One person told us that they had used the service for a number of years, however that there was not one staff member that they knew well. Our observations confirmed that staff did not always take the time to get to know people and had not taken opportunities to engage with people or find out important details about them. This did not treat people as individuals or enable people to comment on how they were being supported. We raised our concerns with the registered manager about the lack of staff interaction, however they failed to identify with our concerns and indicated that they considered the level of staff interaction with people to be appropriate.

Staff did not always involve people in how their care was provided and often talked about people in their presence about their care needs, rather than to them. For example, staff informed a hairdresser that a person sitting nearby had an appointment. Without communicating with this person or making an attempt to help this person derive some enjoyment out of the occasion, they said to the hairdresser, "Do you need anyone else? This is [person's name]." On several occasions we observed that staff did not always inform people before they provided care or reassure the people they were supporting. We observed that staff often ignored the people they were providing personal care to and would talk amongst themselves about their own personal issues. Where staff did communicate with people, they did not always do so in a way that supported people to understand or demonstrated respect. Records did not contain guidance for staff to communicate effectively with people who had complex needs. This meant that people were not supported to feel included and aware of what was happening to them.

We observed that most staff did not respond promptly or express compassion when people required support. On one occasion staff did not attempt to comfort a person who was very upset. A member of staff indicated that there would be no point in approaching the person because, "They're like it all the time," and another staff member gave us similar feedback about this person. When another person appeared distressed due to requiring personal care, staff close by ignored the person and did not comfort or reassure the person that they would be assisted. One person's wishes were not respected when they asked a staff member to support them to sit more comfortably. The staff member declined their request and told them,

"But you always fall down again [in your chair]." The carer accordingly chose to move the person in an alternative way that suited their own needs, rather than meeting this person's request. We saw that the person remained upset following this interaction.

Staff did not always know what was important to the people they supported. Relatives were asked to support the person using the service to complete details of their care plan before they joined the service. Care plans contained generic pre-written text and the registered manager told us that nurses could then personalise care plans further to reflect people's needs and wishes. We found however that this was not consistently done and some people's care plans did not equip staff with the information they needed to provide care in line with people's personal interests and preferences. One person's care plan outlined activities they enjoyed yet this was written in past tense as though this person no longer had these interests. This person was not supported to maintain such interests and details of their present interests were left blank in their care plan.

Relatives and visitors had easy access into the home and could visit whenever they liked. One person told us, "On Wednesdays an exercise person comes to the home and they always want me to go to the lounge to join in."

Staff failed to maintain people's dignity at all times. A staff member advised other staff in the earshot of others that a person required some personal care support, failing again however to address this person directly or offer them reassurance that they would be supported. We saw that six out of the eight people in the main lounge were left wearing the equipment that staff had used to support them to move. The registered manager did not have concerns about this practice in terms of people's dignity and told us that the equipment that people wore was usually obscured where possible.

People were not consistently treated with respect. We saw that some staff made condescending remarks to and about people while they supported them. These included, "I don't know, fancy missing your mouth," "Don't be silly," and "Give [the person] a bib." On three occasions a member of staff bumped into a person who used a wheelchair and did not apologise or acknowledge their action. We noted that a person who was contracted to support people at the home with exercise activities did not address people respectfully and this was not acknowledged or corrected by staff.

Failure of staff to treat people with dignity and respect at all times and communicate with them respectfully is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

We saw that people's needs were usually met in terms of their health and medical needs, however people's care was not always responsive to all of their needs in a way that enabled them to have a good quality of life. One person told us, "They take care of you here." One relative told us, "The care is probably as good as we would get, never 100%." Another relative of a person who had used the service for a long time told us, "They look after [my relative] and do things as needed… they seem to know [them]… they do what they are supposed to do."

A healthcare professional described aspects of good practice at the home and told us that they did not have concerns with the way that they managed people's sore skin. Another healthcare professional spoke positively about the records in place and the care standards of the home and added that the nurses were "Responsible and timely." We saw that the clinical manager displayed a thorough awareness of people's needs.

Some people who used the service were living with dementia, however aids and equipment to support them or encourage their engagement were not in place at the home. One relative told us however that staff did not always support their relative to access aids that they had brought to the home and told us, "I came to visit one day and the curtains were still shut at 10.30am and my relative didn't have any of [these aids to support their engagement]." One person who used the service did not have access to specific equipment that they required and they had been unable to access the garden as frequently as they liked without this support. This person and their relative had not been supported to access this equipment and we prompted the registered manager to help them to do this in order to help improve this person's quality of life.

People and their relatives were asked about their support needs before they joined the service. One relative told us, "They asked about [my relative's] condition and several things." Another relative told us, "We haven't had a meeting yet but I will soon." We asked another relative whether they were involved in regular communication and reviews of their relative's care and they told us, "[We are involved] only as much as if we are asked we are given information and they will ring if there is a problem and we look at [the care records]."

Care plans did not always provide staff with guidance as to how to support and communicate with people in a way that met their needs. Care plans were not always reviewed in a timely way and audit processes were not robust to ensure that this happened or that care plans always reflected people's needs. A relative had complained that one person's specific communication needs were not being met and they had asked for staff to become equipped with the skills to put this person at ease while they were supported; we found that the registered manager had not ensured that staff were guided to respond to people's needs. Staff did not always respond appropriately to another person who showed that they were uncomfortable or distressed and we saw that this aggravated people who used the service and a visitor. The visitor told people who used the service, "It's getting me down, it's not me I worry about it's you. I am sorry I can see it's distracting you," and we saw that although the visitor asked staff to assist, they had failed to do so. While the registered manager intervened and led staff to support this person, the support this person received did not meet their needs and was not compassionate.

There was an activities coordinator in place at the home, who provided examples of activities that people were supported to do. They told us, "I go to all the residents and do an activity with them." Some people who stayed in the rooms were supported with activities which staff told us they enjoyed. A relative told us, "The children from the school came to sing at the home and on Saturday a singer is coming." Another relative told us, "I encourage [my relative] to look at a book but they don't read, they watch television, we ask [staff] to put the television on as company in their bedroom, they mostly do that."

However, we saw that people were not consistently given choices about the activities they were involved in and there was not a structure in place that supported all people to maintain their interests or participate in activities of significance to them. We asked one person what they did after their mealtime and they told us, "Nothing we all go back in the lounge and go to sleep," and we saw that people were frequently left in lounge areas with the television on and limited social interaction. The registered manager provided examples of how people were supported to maintain their religious practices at the home. The registered manager told us that they were making arrangements so that some people could continue to be supported to follow their religious practices as this support had become unavailable. We saw that a poster was on display for a religious service taking place at the home to support people who followed another religion and one person told us about this.

Relatives we spoke with told us that they were promptly informed of any updates or concerns. One relative told us, "If anything [has] happened, they have phoned me, for example if [my relative] is not well and they've called the doctor… I'm given enough information." One relative told us, "If I have any complaints, I let them know; they are approachable and look after [my relative's] needs. They know them very well." However, feedback also suggested that relatives did not always feel confident that their feedback and concerns would be addressed appropriately. One relative told us, "The manager said this is my relative's home now, it made me feel I don't have a say." Another relative told us that the registered manager was not approachable and added, "Sometimes if we need to complain, why wouldn't we, I'm not trying to criticise the way they run it, on the whole complaints are listened to. [A member of the office administration team] is approachable." Although there were systems in place for people and relatives to share feedback and raise concerns, for example through the complaints process, meetings and surveys, some issues that people had raised were ongoing and had not been addressed effectively, and the registered manager had not logged or responded to all complaints in a timely way. One relative told us that they usually addressed concerns with the clinical manager and that these were always dealt with appropriately.

The registered manager provided us with some examples of how they had developed the service in response to people's feedback. However, follow up actions to feedback and concerns were not clearly recorded and the registered manager had no process for formally sharing such progress with people and relatives. We asked the registered manager about a record which showed that that a relative had suggested a solution to address an ongoing concern and the registered manager told us they had, "Decided against [the idea] at the time," yet there was no evidence that they had notified people of this.

People's complaints were not always addressed directly and sensitively by the registered manager and were not always used to identify themes or for learning to improve the service. One complaint detailed a relative's negative experience of raising concerns with staff: 'Carers called me a liar when I am not… When I ask about it I am made to feel have made it up.' We found that the registered manager's response on this occasion did not provide an explanation to the relative as to what had happened and we saw that they had defended staff's response instead of fully addressing the relative's concerns. We asked the registered manager about their responses to concerns and they told us that they took all complaints seriously and prioritised people's concerns whilst maintaining a duty of care in relation to the health and wellbeing of staff. Records showed that where the registered manager had received a complaint from a healthcare professional about a staff

member's conduct, they did not log or investigate this complaint, nor did they utilise this feedback to investigate the issue or assess staff conduct. We found that they had acted to raise a complaint about the healthcare professional's conduct towards staff on this occasion although they confirmed to us that they had not witnessed this incident.

Inadequate

Is the service well-led?

Our findings

We identified concerns about the service and found that the registered provider had failed to establish a person-centred and open culture. The service did not have a clear vision and set of values that guided staff and promoted the safe and caring treatment of people who used the service. The registered provider and registered manager did not always maintain oversight of the service and did not always effectively resolve issues in relation to staff conduct, to keep people safe or ensure that their needs were met. People's care needs and wishes were not always met and this had not been addressed, or assured through robust records and audits at the home. People's care plans did not always reflect their needs and preferences and one audit showed that people's records had not been reviewed or updated for 10 months. We saw that records discrepancies were not identified or addressed in a timely way so that people were protected from risk of harm.

The registered provider did not represent nor strive to meet all of the needs of the people who used the service. Concerns and feedback raised were not always responded to with care. The registered provider and registered manager had failed to effectively grasp and act on all feedback received from people, relatives, professionals and staff, despite some feedback reflecting that basic requirements and processes were not in place for example, relating to communication at the service, staffing and people's care needs being met in a timely way to promote their dignity.

Although some staff were confident in raising concerns and questioning practice at the home, their concerns were not always thoroughly investigated and resolved. Some concerns that had been identified in relation to staff conduct were not effectively acted upon. Staff had queried how the registered manager had intended to address their concerns about one person's behaviours which had put both the staff member and the person at risk of harm. Insufficient action was taken to address these concerns and they were not resolved openly or effectively. During our inspection we were notified by the registered manager that a safeguarding incident had recently occurred in relation to staff practice towards this person, which had put this person at harm.

One relative told us, "Certain carers, they do the job and we don't have to worry." This meant that staff practice was not to a consistent and suitable standard and our observations confirmed this. Staff were not always given clear direction or standard expectations to meet when providing care. Staff had not received all training and direction to meet people's needs and we saw that this had a detrimental impact on some people's care. Records showed that the clinical manager and registered manager had not always maintained oversight as to how staff provided an aspect of care to people and had initially left staff to devise their own methods of organising how they did this. Although some processes had since been implemented to assist staff in providing this support to people, these were not always effective or responsive to people's needs. When we highlighted to the registered manager that records relating to the safe management of people's risks contained discrepancies, they advised us that records would not always be "Bang on time." We saw that the registered manager had relayed a similar message to staff with the clinical manager during a staff meeting, that people's care rounds did not have to be 'bang on' in relation to set times for people to receive care during the night and early in the morning. This meant that staff had not been guided about the

importance of fulfilling their duties in providing the appropriate support to meet people's needs. Prior to our inspection, the registered manager informed us of safeguarding concerns where they had identified that staff had failed to provide care and support to people as required during the night. The home management informed us that staff had been disciplined and that this issue had been resolved.

Staff did not always protect people from harm and some issues where staff had put people at risk of harm through unsafe practice were not learned from or sufficiently addressed so that they did not reoccur. Staff were not always aware of people's support needs or equipped to meet these. Staff were not equipped with the skills to support people with behaviours that challenged and failed to demonstrate a clear understanding or compassion for these people's needs.

The registered provider failed to ensure that people were kept safe by processes in relation to staffing levels, staffing deployment, recruitment and medicines management, within an open and person-centred culture. Records and audits were not always robust to ensure that accidents that had occurred at the home were learned from and prevented.

Failure to meet the needs of people who used the service through robust recording and risk management and effective quality assurance processes is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback showed that the registered manager was not always approachable and accessible to people, relatives and healthcare professionals. One of three people we spoke with knew the registered manager. One person told us, "I wouldn't know them but I've no complaints." A relative told us, "The manager of the home is not very approachable… I'm not particularly comfortable talking to them." Although most healthcare professionals we spoke with provided positive feedback about the home, two healthcare professionals we spoke with told us that the registered manager had not been receptive to their feedback and guidance in relation to people's care.

Relatives and healthcare professionals advised that the clinical manager had been approachable and worked effectively with them and one healthcare professional told us that the service was efficient and organised, and added, "They know what they're doing." Relatives we spoke with advised us that they approached the clinical manager if they had queries. One relative told us, "I have more to do with the clinical manager, they are approachable, they seem to know what's going on." A healthcare professional confirmed this and told us that they had, "An excellent relationship with the clinical manager." One staff member specified that the home was well-led in terms of the clinical care that was provided and told us, "I don't really know about the [care side], from a nursing point of view, we do the best we can. The clinical manager is really on top of the role." This showed that leadership at the home was not consistent and suggested that aspects of service provision were not aligned.

Feedback received during a resident and relative meeting in February 2016 indicated there was poor communication between nurses, managers and relatives and that often communication was 'Absent'. Although the registered manager had taken some steps to address this, our observations confirmed that this issue was ongoing. There was a consistent lack of presence and visibility of nursing support and leadership in the main areas where people resided and received care. We shared our concerns with the registered manager yet they did not act on this feedback to ensure that nurses were present to guide care staff and support people. This meant that leadership was not consistently visible or accessible at the service and appropriate action was not taken to rectify this. We were not able to explore how the registered provider maintained oversight of the running of the home and quality of care that people received.

The registered provider and manager had failed to fulfil all requirements of their registration and did not always conduct their roles in an open and transparent way. The registered manager assured us that they had not received a request for a Provider Information Return (PIR) as part of our inspection process. Our records confirmed that the request had been sent directly to them and they had not completed this process. The registered provider and registered manager had failed to notify the local authority or the Care Quality Commission as required of an occasion where a person had been put at risk as nurses had failed to monitor their symptoms. The registered manager investigated the issue and notified staff that this incident had been, 'A major failing on our part'. The registered provider had failed to notify us or the local authority of another safeguarding incident which had put another person at harm.

Failure to notify the Care Quality Commission of incidents, including injury and abuse of people who using the service, is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009.

Staff we spoke with told us that they were supported by management at the home and we saw that staff had raised some concerns they had, although these were not always addressed effectively. A nurse told us, "It's very nice working here, the manager is helpful." However, we identified concerns in relation to staff culture and records showed that although staff meetings were held regularly, they did not effectively tackle cultural issues within the service that were discussed so that care was centred around people who lived there. The registered provider and registered manager had failed to ensure concerns they raised with staff or identified in audits were always resolved and we saw that they did not always act on the advice of healthcare professionals. Staff meeting records referred to a 'Blame culture' and 'Split between days and night [staff]' at the service and showed that staff often took these opportunities to highlight their preferences about how the home was run and records showed no indication of how these concerns would be managed or addressed. A healthcare professional told us that they had observed 'Antagonism' between the registered manager and staff, with the registered manager, "Negotiating with staff to do the job," and follow their guidance. We raised our concerns with the registered manager following our observation that the needs of the people using the service appeared secondary to the preferences of staff. The registered manager described some cultural staff issues at the home and that they had failed to resolve this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify the Care Quality Commission and other bodies of incidents including injury and abuse of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that people were always treated with dignity and respect, or involved in their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure that the consent and wishes of people who used the service were consistently sought and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that people were always protected from harm through safe practice and care, including effective risk management, safe recruitment practices and medicines management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure that people's nutritional and hydration needs were always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to maintain oversight of the service through robust records and risk management and effective quality assurance processes to ensure that people received safe and caring treatment that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure that there were sufficient staff or appropriate deployment of staff to meet people's needs.