Claremont Care Limited

Elmhurst Nursing Home

Inspection report

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Tel: 01948841140

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23 January 2017

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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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 12, 16 and 23 January 2017 and was unannounced.

Elmhurst Nursing Home is registered to provide accommodation with nursing care for up to a maximum of 37 people. There were 29 people living at the home at the time of our inspection, some of whom were living with dementia.

There was no registered manager in post at the time of our inspection. The service is required to have a registered manager. During our inspection, we met with the home manager who had applied to become registered manager of the service. 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.

At our last inspection April 2016, we found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We gave the service an overall rating of requires improvement. These breaches related to the provider's failure to provide person centred care, provide safe care and treatment, deploy enough suitably trained staff and to ensure decisions made on people's behalf were made in their best interests. We asked the provider to make improvements and to send us an action plan of how they intended to address the shortfalls in care.

At this inspection, we found that provider had not achieved all the improvements required since our last inspection.

There were not enough suitably trained staff to ensure that people received safe care and support that was tailored to their individual needs. Staff were frustrated that they could not always provide person centred care due to a lack of time to do so. Checks were completed on potential new staff to ensure they were suitable to work with people living at the home.

Staff were not always aware of the risks associated with people's needs and lacked guidance on how to minimise these. It was unclear if people's prescribed creams had been applied in line with guidance from the prescriber.

The provider had not consistently worked in accordance with the principles of the Mental Capacity Act to protect people's rights. Staff sought people's consent before supporting them and provided information in a way they could understand to help them make decisions.

People were satisfied with the quality of the food but had limited choice in what they ate. People's dietary needs were assessed and associated risks were managed. Where necessary, people were supported to eat in a patient and caring manner. Staff monitored people's health and sought appropriate medical advice and

treatment as necessary.

People's private space and surrounding environment were not always respected. People's dignity was not always maintained. People felt staff were kind and caring. People were supported to make choices about their day-to-day care. People felt happy and safe with the care provided to them.

Staff had access to an ongoing programme of training. Staff were supported by their seniors and colleagues who were able to give guidance and advice when needed.

People and their relatives were given opportunities to provide their views on the development of the service. People and their relatives felt able to approach staff or management with any concerns they may have. The provider had a complaints procedure, but this was not consistently followed.

The systems the provider had in place to monitor the quality and safety of the service were ineffective in identifying all the shortfalls we had found. The manager was working towards improving the service, but this had not been sustained due to insufficient resources.

The manager had a clear vision for the service that both staff and management worked towards.

You can see what action we told the provider to take at the back of the full version 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.

There were not always enough suitably trained staff deployed to support people safely.

Staff were not always aware of the risks associated with people's needs or actions they needed to take to minimise them.

Staff had received training in how to recognise and report signs of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not consistently worked within the principles of the Mental Capacity Act to protect people's rights. Staff sought people's consent before supporting them.

People enjoyed the food but had limited choice in what they ate.

People were supported to access healthcare when needed.

Staff received training relevant to their role.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's private space and surrounding environment were not always respected.

People's dignity was not always protected.

People felt staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive care and support that was suited

to their individual needs and preferences.

People felt able to raise concerns but outcomes of complaints were not always recorded.

Care was task-focussed and there was a lack of stimulating things to do to support people's emotional wellbeing.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The manager was working towards improving the service but this had not been sustained due to insufficient resources.

The systems the provider had in place to monitor the quality and safety of the service were ineffective in identifying all the shortfalls we had found.

The manager had a clear vision for the service that was shared and worked towards by staff.

Elmhurst 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.

This inspection took place on 12, 16 and 23 January 2017 and was unannounced. The inspection was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

The provider, Claremont Care Limited, went into administration in February 2016. The administrators of the home have employed a temporary provider to manage the service on their behalf.

During the inspection, we spoke with 10 people who used the service and four relatives. We spoke with 19 staff which included the home manager, the provider, three nurses, nine care staff, the activities and maintenance workers, one office and two kitchen staff. We also spoke with two health care professionals by telephone. We viewed nine records which related to assessment of needs and risk. We also viewed other records which related to management of the service such as medicine records, accidents reports and two recruitment records.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is specific way of observing care to help us understand the experience of people who were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that people did not always get the support they needed because there were not enough suitably trained staff effectively deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how they would achieve this.

At this inspection, we found that there were continued concerns about staffing levels at the home. One person told us that staff sometimes took a long time to respond to their call bell. They described a time when they needed support with their personal care needs. They had timed the staff's response and had waited for as long as 40 minutes for staff to attend. They said, "It made me sore. They (staff) said they were dealing with something else, but it has happened more than once." Another person told us "They (staff) are slow to come to me. I call for help and they take a long time to come. This happens wherever you are. There is a call thing I have, but they are slow"

A relative we spoke with said, "I think they could do with more staff. They are always rushing and don't seem to have a minute to stop." We looked at surveys responses completed by people's relatives. One relative wrote, "You need more staff. I saw a person eating out of a bowl with their hands. More staff are needed to feed and hoist and take to the toilet." Another relative had written, "Need more staff, although they are lovely."

Staff we spoke with described stressful working conditions where they struggled to meet people's needs. One staff member told us that the home was very short staffed, and that shifts were 'always stressed'. They explained that on an early shift it was often 2 p.m. before everyone was washed and dressed. They said staff would sometimes cut corners due to lack of time, such as changing people's continence pads without giving them a proper wash. The management had informed them there was not enough funding to increase staffing levels and had told them, "That's what we are given; you have to work with it." The staff member went on to tell us, "Staff stay over their shifts to try and get things done." Another staff member said, "We try to do the best for people, but we run out of time because everybody needs so much care." A further staff member told us, "We have a duty of care to these people which we sometimes cannot meet." They explained they tried to make time for people who needed them, but this then had a knock-on effect for people who were waiting for support.

All the nursing staff we spoke with felt that their workload was unmanageable when there was only one nurse on duty in the mornings. During such times, the nurse was expected to complete the morning medicines rounds on their own and these would not be completed until 11.30 a.m. They told us and we saw that they were often disturbed by staff who wanted them to check on people or to give them guidance. This meant there was greater scope for errors, as they should not be disturbed when administering medicines. The nurses had raised concerns about the safety of staffing levels with the provider. One nurse said, "It's not for the want of saying. I've told them it is unsafe. We were made to feel you have to prove that more staff are needed. We are not getting to the next priority and it is frustrating." The nurses felt that the lack of a second nurse each morning impacted on their ability to safely meet people's needs. They told us they also struggled

to ensure that people's care plans and risk assessments were kept up to date and accurately reflected their support needs.

On the first day of our inspection we observed that staff were rushed and call bells rang continuously throughout the day. Staff did not have time to spend with people apart from when they were providing support with personal care and meals. We looked at the staff meeting minutes for the 21 November 2016 which made reference to action staff should take if they did not have time to give people full care. The minutes recorded stated, "If there is genuinely not enough time to give all residents full care, i.e. wash/bath/shower, at the very least all residents must have basic 'top and tail' plus teeth cleaned, for the men, shaved and hair done." The minutes went on to say that staff should discuss their plans with people to ensure they were happy with the arrangements.

We spoke with the manager who had recognised the pressures on staff and requested additional staffing to safely meet people's needs. The provider confirmed that they had told the manager staffing levels were in line with national guidelines and they would need to justify requests for additional resource. The provider told us any increase in staffing would need to be agreed with the administrators for the home. Additional staffing was subsequently authorised but, this had not been sustained at the time of our inspection.

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

Staff had received safeguarding training and were knowledgeable about the different forms of abuse. They demonstrated that they would take appropriate action should they witness or become aware of abuse taking place. One staff member told us, "I would report concerns straight away don't you worry. I'll go to the top." Another staff member said they had raised safeguarding concerns with the manager. We found that the provider had made two referrals to the local safeguarding team. They had completed investigations into the concerns raised and revised processes to prevent reoccurrence.

We looked at how people were kept safe. Staff told us they referred to people's care plans and observed and reported any changes in their needs. If they were unsure about anything they said they would speak to the nurses. We looked at people's care records and found risks associated with people's care needs were not always recorded and plans implemented to manage these in a timely manner. For example, a nurse told us they had reported a safeguarding concern to the manager. When we asked what had been put in place to reduce the risk of harm to this person a nurse told us told that staff were aware of the risks and actions required of them. However, when we spoke with staff we found that not all of them were aware of the risks and the action they needed to take to ensure the person's safety and wellbeing. This meant that the person remained at risk of harm. When we spoke with the provider they committed to addressing the existing gaps and to ensure that risk assessments and care plans were completed in a timely manner in the future

At our last inspection we found that people's medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how they would do this. At this inspection we found some improvement had been made. The nurses told us and we saw that where people needed to take medicines at specific times this was accommodated. We found medicine administration records were better maintained by the nursing staff. However, we found further improvement was required around the application and recording of prescribed creams by care staff. The manager had recognised this as an area for improvement. They showed us the new system that they were introducing to ensure care staff applied people's creams as prescribed. This included a body map of where creams were to be applied and improved MAR for staff to complete. We were unable to comment on the effectiveness of this system during

this inspection and this will be looked at when we next visit.

People told us they were satisfied with the support they received to take their medicines. One person said, "They (staff) do all my tablets. I do feel safe with them doing it." Another person told us they trusted staff to give them their medicine as they were "careful". We observed the nurses giving several people their medicine and they did so in a patient manner. They ensured people were comfortable and gave them a drink to take their medicines with.

People we spoke with felt safe living at the home. One person told us, "I do feel safe here. I moved from another home, but I am getting used to it and do feel safe. I have an alarm thing I take around with me." Another person said, "Yes, I do feel safe here especially at night in my bed. They (staff) sometimes come and sit with me so I feel nice and secure." A relative told us, "Apart from what [family member] says about the alarm response they are safe I reckon." Another relative said they felt that their family member was very safe and they had no complaints at all.

Two people we spoke with told us that some staff were sometimes rough when supporting them to move around and that they had spoken to management about this. When we spoke with the manager they told us they discussed concerns about staff practice in staff meetings. This was confirmed by staff we spoke with and in staff meeting minutes we looked at. During our visit we observed that people were supported to move around the home safely. Where staff needed to use equipment to move people we saw that staff explained what they were doing and provided reassurance where necessary. Where people were at risk of skin breakdown staff told us they ensured they were repositioned at the required times. If they noticed any changes in people's skin condition they reported these to the nurse. A nurse showed us that they had a system in place to ensure that dressings were changed as required. The nurses told us and we saw they referred people to the tissue viability nurse if they had concerns about people's wounds.

Staff told us that pre-employment checks were completed before they were able to start working in the home. These included the provision of two references and Disclosure and Barring Service (DBS) checks. The DBS helps employers to make safer recruitment decisions. Records we looked at confirmed that the provider followed safe recruitment procedures.

Staff demonstrated they knew how and when to report accidents and incidents. They made sure the person was safe and called for the assistance of the nurse. In the event of a fall the nurse completed a full body check and arranged medical attention if required. They subsequently completed the accident form and where appropriate informed the person's relatives. The manager told us they looked at what action was required to reduce reoccurrence and to analyse if there were any trends. For example, when one person had fallen out of bed they had put in place a low-rise bed and placed a mattress on the floor to reduce the risk of injury.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that people's ability to make decisions about their care and treatment had not been appropriately assessed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and send us a plan to tell us how they would do this.

At this inspection we saw that some improvements had been made but further work was required to ensure people's rights were protected. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Following our last inspection the provider told us they would ensure that best interests decisions included the full involvement of families. We looked at the records of two people who had been assessed as lacking the capacity to make certain decisions. Whilst their mental capacity had been appropriately assessed, we found that the best interests decisions had not involved their relatives or advocates. Where professionals such as physiotherapists and GPs had been involved it did not name who these professionals were.

We found that there was a delay in completing capacity assessments for two further people who had recently moved into the home. This meant that decisions were made for these people without a mental capacity assessment and best interests meeting taking place. For example, one person had bedrails put in place to reduce the risk falls. However, a mental capacity assessment and best interest decision had not been completed for them. It was therefore unclear if the decisions made were in the person's best interest or the least restrictive.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether 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. We saw that the provider had appropriately submitted DoLS applications to the local authority and were awaiting authorisations. On the third day of our visit a DoLS assessor and an Independent Mental Capacity Advocate (IMCA) visited a person at the home to complete a DoLS assessment.

Staff we spoke with had a good understanding of the MCA and what this meant for their practice. They told us they assumed people had capacity unless there was reason to believe otherwise. They felt that most people had the capacity to make day-to-day choices about their care and support. One staff member told us they always explained to people what they wanted them to do. They gave them choices in a way they could understand and respond to. If a person declined their support they would leave them and go back later. If that failed, they would see if they responded better to another staff member. We observed that people were provided with choice and supported to make their own decisions where able.

People and their relatives felt that staff had the skills and knowledge to meet their individual needs. One person told us, "They (staff) are very good. They know exactly what I like." A relative said, "They (staff) are all very good and know [family member] well."

Staff we spoke with told us they had access to a range of training. One staff member explained that a new trainer had recently been employed. They felt the trainer was very good, and told us, "It keeps us up to specifications. You need reminders." Another staff member told us as well as face-to-face training they did on line training. They said they received an email alert to tell them when training was due and then had month to complete it. Two staff members told us they would like more training in managing challenging behaviour. They explained that several people were prone to hitting out at them when they supported them with their personal care. They felt training in this area would enable them to recognise the triggers in order to support people better and to protect themselves from injury. When we spoke with the manager they told us they were exploring options for the delivery of training in managing challenging behaviour. In the meantime staff were advised to follow the behaviour support plans in people's care plans.

We spoke with a new staff member about the induction training they received when they started work at the home. They told us they worked alongside a senior member of staff until they felt confident and able to support people on their own. The manager told us in addition to the standard induction new staff would be supported to complete the Care Certificate. The Care Certificate is a nationally recognised programme that trains staff about the standards of care required of them.

Staff told us that although they had not received regular one-to-one supervision meetings they could approach their seniors for support at any time. When we spoke with the manager they told us that regular supervisions had not been achieved. This was because they first wanted to ensure staff with supervisory responsibilities had the training and confidence to fulfil their role. They showed us that they had developed a schedule of one-to-one meetings to commence in February 2017. In the meantime they had completed group supervisions with staff to discuss specific areas of concerns. They told us they had an open door policy and encouraged staff to speak to them if they required guidance or support.

People we spoke with told us they were satisfied with the food they were provided but were given limited choice. One person told us, "The food is good but you don't get a choice." Another person said, "The food on the whole is alright but if there is something I desperately don't like they will do something else for me." A relative told us that they had written a list of the food their family member disliked. However, they had found that this was ignored as staff still served their family member with things they did not like. When we spoke with the manager they explained that attempts to include people in the development of menus had been dismissed by previous managers. They said they intended to meet with the kitchen staff to explore how they could better involve people in developing menus to suit their preference and dietary needs.

We spoke with the chef and kitchen assistant who had a list of people's dietary requirements, such as soft or pureed diets. They showed us the menus prepared for the following few weeks. This did not include any choice. However, the chef told us they were flexible and would prepare an alternative meal if a person wanted something different.

People's nutritional needs were routinely assessed, monitored and reviewed by nursing staff. Plans had been put in place to manage the associated risks incorporating the advice of relevant professionals, such as the speech and language therapist (SaLT) and dietician. Staff were aware of people's dietary needs and supported them accordingly. For example, one staff member told us, "I try and cajole them, help them if they need it. I encourage people to try something different. I also let the nurses know if someone is not eating

well." Where necessary, staff supported people to eat and drink enough. We observed that staff supported people in a patient and dignified manner. Staff told us they completed food and fluid charts to monitor what people ate and drank. However, we found that these were not consistently completed. This had been recognised by the nurses who were reviewing their current processes and documentation. We saw that where concerns had been identified these had been appropriately referred to other professionals, such as the GP or dietician.

Staff monitored people's health and arranged healthcare appointments as necessary. On the first day of our inspection one person told us, "I am poorly with my chest so in bed a lot at the moment. The doctor is coming later." Staff we spoke with told us they reported any health concerns to the nurse. A nurse confirmed that when staff felt people were unwell they completed observation checks and reported their findings to them. The nurse would then determine whether the person needed to be referred to the GP. The manager told us the GP visited the home on the weekly basis. There was a clear process in place for requesting the GP and recording the outcome of their visit. We saw that changes in people's health and outcome of medical visits were shared at staff handover and handover sheets were available for staff to refer to if needed. There was also evidence of regular medicine reviews taking place.

Requires Improvement

Is the service caring?

Our findings

On the first day of our inspection we found the home to be cluttered and untidy. The cushion pads on chairs in the lounge were upturned and looked uninviting. The hallways and lounge areas were cluttered with pieces of equipment, such as wheelchairs, hoists and a weighing chair. We saw that some people's bedrooms were untidy. In one person's room we saw that their armchair was piled with various items including clean laundry which had not been put away. In one bathroom we observed that there was a hole in the wall and an uneven floor where the bath had been removed. Equipment was also stored in this room. This showed a lack of consideration and respect for people's experience of their environment.

On the first day of our visit we observed that one person's trousers were worn thin and had holes in them. We told staff about this. However, on the second day of our visit we saw that the person had the same trousers on. The person told us that staff had helped them dress that morning. When asked about the holes in their trousers, the person said they were not aware of the holes due to their poor eyesight.

On the whole, people and their relatives found staff to be caring and kind. One person told us, "The staff are nice and caring. I have no complaints." Another person said, "I love all the staff. There are a couple who I have had to remind them about their manners and they are great now. The staff are my friends; I feel safe with them. Nothing is too much trouble for them. They know me well." A relative told us, "I have been very happy with the care. I personally would recommend them and have done so to friends and relatives." However, two people told us the staff approach was variable. One person said, "Some (staff) are very nice and more caring than others and take time with you. Others don't." Another person said, "Most are pleasant but, like I said, I have a personality clash with some of them." When we spoke with the manager they told us they had recently changed care agency due to concerns raised by people about the attitude of some staff from the previous agency used. They told us and we saw that they had used staff meetings to discuss concerns raised and standards of care required. Throughout our visit we observed people were comfortable and happy in the presence of staff. There was laughter and smiles when staff supported them.

People and their relatives told us people were offered choice and staff listened to them. We spoke with a relative of a person who was receiving end of life care who told us, "We prefer [family member] to be here rather than in hospital where they are with (staff) who know and love them." They went on to tell us, "The night nurse has been excellent. They have been supportive, sensitive and thoughtful towards us all night long."

Staff we spoke with told us they supported people to make choices, such as, what they would like to wear. One staff member said, "It's all about them, not about me." They went on to explain they did things the way people wanted them to be done. Where staff had difficulty communicating with people verbally they said they would show them choices. They would ask the person to point or they observed their body language to establish their wishes.

Staff told us that they promoted people's dignity by covering them up when providing personal care. They ensured that they were not unnecessarily exposed when supporting them with the hoist. Staff spoke with

and about people with kindness and a desire to make them safe and happy. One staff member said, "I love my job. I just love being with them." They went on to say, "I'm here for the people. I come in and I enjoy my job. If I can make them laugh, I've done my job."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that people did not receive care and support that was tailored to their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and send us a plan to tell us how they would do this. At this inspection we found insufficient improvements had been made.

The provider told us in their action plan that care plans would be completed to reflect people's needs and choice. However, we found that there was a delay of between one and eight weeks in developing people's care plans. It was therefore unclear how people had been involved in shaping the care and support they received. These included people who were unable to make their needs known due their illness and were therefore dependent on staff to interpret their needs. When we spoke with the nurses they told us they had not had not completed the required documents because of a lack of time to do so. This meant that some people were at risk of receiving support that was not tailored to their individual needs and preferences. Staff told us they asked people how they would like their care to be provided where they were able to. In other instances they told us they referred to people's care plans and if they were unsure of anything they would speak to the nurses. We spoke with the manager and nurses to establish how they ensured staff were aware of people's needs and associated risks. They told us staff could refer to the initial assessment and information provided through staff handover. When we spoke with the provider they said they were not aware of the delays as they had not audited the records of these particular people.

People and their relatives told us staff had limited time to spend with them and therefore they had little opportunity to partake in activities they enjoyed. One person told us, "They (staff) don't seem to have the time to stay and talk. I do miss that." Another person said, "There isn't a great lot to do. They could do with putting more on I think." A third person said, "There are things to do but not a great deal. They do have trips out sometimes and do quizzes. We had a horse visit us; that was nice. I would like music but they never seem to put any on." On the first day of our inspection the activity worker was not in work. We saw some people watched the television, one person sat by the window looking out while others sat doing nothing. On the second day of our visit we saw that the activity worker engaged some people in group activity and spent one-to-one time with some people. When we spoke with staff they told us they did not have time to spend with people. This meant people did not have opportunities to follow their interests or receive stimulation when the activity worker was not in work.

Staff we spoke with told us that there were not enough staff and therefore a lack of time to meet people's individual needs and preferences. One staff member told us, "We don't get enough time with them. We don't have time to sit and reassure them. We are in and out and it is not fair on them." They went on to explain that they only got to spend time with people when they were helping them with personal care and meals. Another staff member described a rushed morning routine they said, "The moment you have finished with one person you are on to the next. Then in the afternoons you have got the turns to do." We are doing the necessities and do not always get the time to sit and talk with them. Staff felt that their work was task-based and that this impacted on people's and staff's emotionally wellbeing. One staff member said, "We all feel that, sometimes, we have worn ourselves out and still could have done better for people. It is so frustrating

at times." Another staff member told us if there was one thing they could change about their work, it would the ability to spend more time with people.

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

The manager told us staff had received training on person centred care and wanted to provide care and support that was personalised to each individual. They recognised that staff had little time to spend with people and were in discussion with the provider in regards to this. In the meantime, they were looking at how they could use their current resources better. They said they had kitchen and domestic staff who used to do care work and would explore if they had the capacity to assist with care tasks at busy times of the day. They had spoken with the activities worker about how they could utilise their time more effectively. They were aiming to introduce a reminiscence area in the lounge. The activities worker told us they were researching the internet for ideas and resources that could be used. A relative had recently donated some furniture they were going to use to support an 'olde worlde' theme that encouraged reminiscence. The activities worker told us they had regular contact with people and their families. They were going to do life history work with people and this would be incorporated into their care plans for staff reference.

People and relatives we spoke with had not made any formal complaints. However, some had made representations when they were not happy with meal choices and how they were helped to move around. One person told us, "I tell them straight so they know where they stand with me." We saw that the provider had a complaints process in place. However, the outcomes of complaints were not available to staff members to aid their learning and how they could prevent reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that there were multiple breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan of how they intended to address the shortfalls in care.

During this inspection we found improvement had been made in some but not all areas. The provider had not completed all the actions they had said they would within the timescales they had set.

At the last inspection the provider had not notified the Care Quality Commission (CQC) of two safeguarding referrals they had made to the local authority. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. In their action plan the provider told us they would immediately report any incidents of abuse to both the local authority and CQC. By law the provider must notify CQC of certain events, these are called statutory notifications. Since our last inspection, the provider had referred two further concerns of abuse to the local authority safeguarding team but had failed to notify CQC of these events. The manager and clinical lead told us they were not aware of this requirement and would ensure CQC were notified of any such incidents in the future.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The provider had checks in place to monitor the quality and safety of the care provided. These included care plan and medicine audits completed by the nurses and monthly audits completed by the provider. However, these had not been effective in identifying all the shortfalls we had found such as, the lack of care plans and risk assessments for some people. There had also been a delay in completing mental capacity assessments for people which meant that their rights were not always protected.

The provider had failed to consistently support people to express their views and preferences for care delivery. The provider did not ensure adequate resource or stimulation to support people's emotional wellbeing.

We found that the dependency tool that the provider had put in place to determine staffing levels was ineffective. The provider had requested additional information from the manager to justify an increase in staffing levels. This was despite concerns raised by people, their relatives and staff about the safety and the responsiveness of the service.

The manager told us they were working towards improving the service, but this had not yet been sustained due to insufficient resources. When they started work at the home, they were the only permanent nurse and at that point did not have any administrative support. They had found that there was a lack of systems and processes in place and they had to start from scratch. They said their initial focus was how to keep the home afloat.

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

2014.

The manager had been in post since July 2016 and had applied to become the registered manager of the home. They told us the provider had shared with them the action plan they had developed following our previous inspection. They recognised that all round improvement was required for the benefit of the people living at the home and staff. They told us their aim was to provide an outstanding service as this was what people deserved. They acknowledged they had 'a lot of hurdles to climb' but were willing to put in the extra hours required to achieve their vision. They said, "I'm doing this because I care. It's not just about the residents but the staff as well."

People and relatives knew who the manager was and on the whole thought the atmosphere at the home was good. One person told us staff were very good and that they were happy living at the home. Another person said, "They (staff) do try most of them." A relative we spoke with said, "I know there have been concerns raised but as far as I am concerned they (staff) are all excellent." A relative we spoke with told us that they attended a monthly meeting held at the home where they were kept up to date with plans for the home.

The manager told us they were keen to involve people and their relatives more in the development of the home. They had conducted a relative's survey and the activity worker was going to do a survey with people living at the home. They had recently introduced 'resident of the day'. The aim was for staff to focus on one particular person each day. This involved reviewing people's care plans with them and their relatives, a deep clean of their room and 'pampering' for the person. We unable to comment the effectiveness of this system at this inspection as it had only just been brought in and we will review it at our next visit.

Staff were motivated by the vision the manager had for the service. One staff member said, "[Manager] is very good, I'm glad they are back. They were good as a nurse and they care." They went on to say "[Manager] is passionate. They want us all to feel safe and relaxed like it's home from home." Another staff member said, "[Manager] is putting their heart and soul into the place." Staff described a supportive environment where they worked together to achieve better care standards for people. One staff member told us, "At the moment we have got cracking staff. We have now got a good team. Communication is key." Another staff member said, "We have to learn to prioritise our work. We work as a team and support each other." Staff said they also benefitted from regular agency staff who worked well as part of the team. They felt this helped as they had got to know the people and provided consistent support. This was confirmed by a staff member who said, "We do get the regulars and they do fit in. You can trust them to do things we ask them to do, which is worth a lot."

The provider had systems in place to give staff the opportunity to voice their views and opinions. These included a staff survey, team meetings and one-to-one meetings. Staff told us and we saw that team meetings were held on alternate months. They were encouraged to add agenda items and felt comfortable and able to put forward their views and ideas at these meetings.
The manager told us they were keen to develop their staff team. They therefore kept abreast of best practice through links with the local training partnerships and colleges. They liaised with resources such as, the local hospice and tissue viability service for guidance and support. They had introduced a learning resource board with information about specific illnesses people were living with, such as epilepsy and diabetes. They had identified staff had interests and skills in specific areas such as, dementia care. They told they intended to invest training and support to develop staff so that they could become the experts in areas of interest. This would enable them to support other team members. The manager confirmed they had secured an online training resource package which together with face-to-face training enabled staff to broaden their knowledge and skills. They showed us they had systems in place to monitor staff training.

The manager explained there had been many changes in management at the home over the past year and relationships with other professionals had suffered. They found they needed to 'build bridges' to restore confidence in the service. They had liaised with professionals who supported the home and were working with them to drive improvements in the standards of care. This was confirmed by two health care professionals we spoke with. One health care professional we spoke with had been impressed by the clinical lead. They found them to be "caring and compassionate" They felt that their main drive was to improve the service. They had also found staff were prepared to listen to and follow guidance given.

The home maintained links with the local community. Two people continued to attend the local day centre, the local church visited and a person from the local village visited and played the keyboard to people.

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 provider had not notified of serious incidents that they are required to send us by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people received person centred care.

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 provider did not robust systems in place to drive improvements in the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that enough suitably trained staff were deployed to meet people's needs.

The enforcement action we took:

We served a Warning Notice on the provider to be compliant with the Regulations by the 24 March 2017.