East Anglia Care Homes Limited

Sutherlands Nursing Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

Sutherlands Nursing Home offers accommodation for up to 52 people who require nursing or personal care. The home is located in a residential area on the outskirts of Wymondham, is purpose built and accommodation is offered on two floors. Internally, the home is divided into four units, each with a number of bedrooms with ensuite facilities, a sitting/dining area and bathrooms. The three units on the ground floor are all linked and offer a service mainly to people who need nursing care. Minton unit on the first floor offers accommodation for up to 12 people who are living with dementia. At the time of the inspection the two double bedrooms on this unit were being used as singles.

This comprehensive inspection took place on 10 and 18 August 2016 and was unannounced. There were 34 people living at the home when we visited.

This home requires a registered manager as a condition of its registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. At the time of this inspection there was no registered manager in post. The provider had appointed a manager who, on the first day of our visit to the home, had been in post for 10 days. The previous manager, who had not been registered, was working at the home as a nurse. People, relatives and staff were all very impressed with the new manager and had confidence that changes would be made.

We last inspected this service on 26 and 28 January 2015 when we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of two regulations relating to staffing and good governance. Following that inspection, the provider sent us an action plan, detailing how they intended to meet the regulations. The provider wrote that all actions would be completed by 5 June 2015.

At this inspection we found that the provider had failed to take effective action and continued to be in breach of regulations relating to staffing and good governance. We also found that the provider was in breach of four further regulations relating to medicine management; consent; meeting nutrition and hydration needs; and notifications. You can see what action we told the provider to take at the back of the full version of this report.

People told us they felt safe and that they enjoyed living at Sutherlands Nursing Home. Staff had undergone training in safeguarding people from harm and they demonstrated they knew how to recognise and report any incidents of harm. Recruitment procedures ensured that only staff suitable to work at this care home were employed.

There were not enough staff to ensure that people were safe and that their assessed needs were met in a timely manner. This put people and staff at risk of harm.

Assessments of potential risks to people and to their health had been carried out and guidance recorded but staff had not always followed the guidance. There were a range of issues with the way medicines were managed and we could not be assured that people received their medicines safely and as they had been prescribed. Infection control procedures were not always followed, creating a risk of cross infection.

Staff had undergone training to provide them with the skills and knowledge they needed to carry out their role. However, some staff did not always put their training into practice.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed and applications for DoLS authorisations had been made for people assessed as having their liberty restricted. However, the procedures in place were not robust enough to ensure that the rights of people who did not have capacity to make decisions for themselves would be protected.

People were supported to maintain good health and their healthcare needs were met by the involvement of a range of healthcare professionals. People were not always given sufficient amounts of suitable food and drink to ensure that their nutrition and hydration needs were met.

There were some warm and caring interactions between the staff and the people they were supporting. People and their relatives praised the majority of the staff and their compassionate, caring attitude. Staff knew people's needs well and respected people's privacy and dignity. People were not always given opportunities to make choices in some aspects of their lives. Visitors were welcomed to the home at any time.

Care records were not always complete or up to date and guidance for staff was not always available. People's past lives had not always been taken into account in providing their care. Charts to record aspects of people's care were not always completed in a way that would provide detailed information to monitor and direct the care delivered.

Activities members of staff had been appointed and were developing a range of activities, outings and entertainment based on people's individual needs. Complaints had not always been responded to appropriately.

The provider's quality assurance process had not been effective in driving improvement in the service provided to people who lived at Sutherlands Nursing Home. Audits had identified a number of issues but the lack of action plans, monitoring and timescales resulted in the issues not being addressed. Audits from external agencies had not been used to improve the service.

People, their relatives and staff were not encouraged to share their views about the service being provided. Not all legal requirements were met by the service and we found that the provider had not notified CQC about allegations of abuse. Records were not always completed as required.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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 always safe.

There was not a sufficient number of staff on duty to ensure that people's needs were met and that people were kept safe.

Potential risks to people had been identified and assessed but had not always been managed to ensure that risks to people's safety were reduced. Staff had undertaken training in safeguarding and knew how to keep people safe from harm.

The management of medicines was not satisfactory and did not ensure that people received their medicines safely and as they had been prescribed. Infection prevention and control measures had not always been adhered to.

Staff recruitment had been done in a way that made sure that only staff suitable to work in a care home were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The application of the MCA and DoLS was not robust enough to ensure that people who lacked mental capacity to make certain decisions had their rights protected.

Staff had undertaken training to provide them with the knowledge and skills to carry out their role. Some staff did not always put their training into practice and staff had not received regular supervision.

People's needs for adequate and appropriate food and drink were not always met. People's healthcare needs were monitored and met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and caring and treated people with respect for their privacy and dignity.

People were not given enough opportunities to make choices about their daily lives.

Visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place but were not always up to date or accurate. Staff did not always follow the guidance in the care plans.

Charts to record some aspects of people's care were not always completed in a way that provided details to monitor and direct the care provided.

Activities members of staff were developing a range of activities, entertainment and outings based on people's individual needs.

A complaints procedure was in place but not all complaints had been responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have a robust quality assurance process in place to identify shortfalls in the service being provided and drive improvement.

Audits carried out had identified areas for improvement but no action had been taken.

There was no registered manager in post. A new manager had been appointed.

People, their relatives and staff were not encouraged to share their views about the service being provided and their views had not been taken into account in the development of the service.

Notifications had not always been sent to CQC as required by the regulations.

Care Quality Commission

Sutherlands 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 home, and to provide a rating for the service under the Care Act 2014.

This inspection included two visits to the home. On the first day there were two inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. The visits were completed on the second day by one inspector.

Prior to the visits we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

Before the inspection, the provider completed 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.

During our visits to the home we observed how the staff interacted with people who lived at Sutherlands Nursing Home. We spoke with nine people who lived there, seven members of staff (one nurse, the activities coordinator, one senior care worker, three care workers and one domestic) and the manager. We also spoke with four people's relatives, six visiting healthcare professionals and two commissioners. We looked at five people's care records as well as some other records relating to the management of the home. These included some of the quality assurance audits that had been carried out.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 26 and 28 January 2015 we found that people's needs were not being met as there were insufficient numbers of staff deployed to support them. The provider sent us an action plan in May 2015, in which they told us they had taken action so that 'staffing levels reflect dependency'. They told us this had been completed by 20 April 2015.

During this inspection we found that the provider had not taken effective action and was still in breach of this regulation. There were not enough staff deployed to keep people safe and fully meet their assessed needs.

People were not always safe because there were not sufficient staff to meet their needs on Minton unit. There were three staff members on the unit. However, one agency staff member was providing one-to-one care to one person because of the behaviour they exhibited. This meant that two staff were supporting eight people living with dementia, two of whom had behaviour that challenged themselves and others and they became agitated if their space was invaded. Staff said that all people on the unit required two staff to assist them with personal care. When staff were providing personal care to people in their bedrooms, staff told us that people were left in the lounge area with no supervision. This meant people were not protected from avoidable harm.

The provider told us that a number of other staff, such as the manager and deputy manager, the activities coordinator, the nurse on duty and cleaning staff were "wandering around." However, the provider could not guarantee that any of these staff would be on the unit when the care staff were supporting people in their bedrooms. An incident record from July 2016 showed that an incident had taken place between two people when no staff were in the lounge. The manager told us they had recognised that a third member of staff was needed during the day.

During the night before our second visit the person who received one-to-one support during the day had been extremely unsettled and had been screaming and shouting for most of the night. They did not have one-to-one support at night. There had been three care staff and one nurse on duty for the whole home. The manager told us this had had "a horrendous effect" on other people in the unit, who had then required additional staff support because they were so upset and anxious.

People downstairs, their relatives and staff also told us there were not enough staff. On the first day we visited, we saw that one person was not assisted with their lunch until 1.40pm. At this time, one person had still not received their morning personal care. One relative told us they came in at lunchtime to make sure their family member was assisted with their lunch. They did not have confidence that staff had the time to make sure their family member, who ate slowly, was given sufficient time to eat their meal. Staff told us, "Staffing levels need to improve," "Not enough care staff at present" and "What could improve? – more staff." We asked one senior member of staff what effect staffing levels had. They said, "It puts staff under huge pressure. The biggest problem is when staff go off sick at the last minute, or don't turn up." The manager told us that recruitment of staff was on-going; a 'clinical lead' was due to start in September; and

two or three care staff would be starting as soon as their pre-employment checks had been returned.

In the PIR, the provider told us that 'Dependency ratings are checked and updated weekly.' The provider used a recognised tool to assess people's needs and determine the number of staff required in the home. This had not been effective in identifying that there was not a sufficient number of staff to keep people safe and fully meet their needs.

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

We checked the way medicines were managed and found there were a number of issues. We looked at nine people's medicines records. These records included care plans, which gave staff instructions and guidance relating to the way particular medicines should be dealt with for individual people. The care plans had not been reviewed or updated since they were first written. For example, for three people, care plans were dated April 2014; May 2015; and August 2015. Some of the care plans related to medicines that the person was no longer taking. One care plan was entitled 'for travel sickness' but the name of the medicine was not included on the care plan.

We also found that care plans for some people's medicines were not in place. For example, one person had been prescribed eye drops to be used 'when required'. There was no care plan to guide staff on what to look out for so that they would know when the drops should be used.

We tried to check whether the amounts of medicines remaining in their packets tallied with the medicine administration record (MAR) charts. However, we were not able to do this as amounts of medicines remaining from the previous cycle had not been carried forward. For one person we noted that zero tablets had been received from the pharmacy and zero tablets had been carried forward. However, staff had signed the MAR chart to show that the person had been given four tablets. The provider had devised an 'audit sheet' for each person for keeping a running balance of medicines prescribed to be taken 'when required'. A number of these 'audit sheets' had been completed inconsistently and incorrectly and the balance did not always tally with the actual numbers of medicines remaining in the packets.

MAR charts had not been fully or correctly completed. Hand-written entries on MAR charts had not been signed or dated and there was no indication as to who had changed the prescription or when. For example, one person had been prescribed an anti-psychotic medicine to be taken every morning. A hand-written entry 'when needed' had been added to the MAR chart. The person had been given the medicine on two mornings out of the eight on the current chart. Another person had been prescribed a pain killer, one or two to be taken when required. The MAR chart had been changed to 'one or two at 8:00am'. For some medicines, staff had not indicated the quantity of a medicine given that had been prescribed with a variable dose. Following the inspection the provider asked us to include an explanation relating to this, in this report. The provider stated, "We accept those concerns, which arose out of us having to rely on non-regular staff (e.g agency staff) because of action we had to take against a poor performing nurse and two other nurses who went off sick for a substantial period.

MAR charts had not always been signed as required to show that medicines had been given. For example, one person had been prescribed a food thickener, to be used in all liquids to reduce the risk of the person aspirating fluids. The current MAR chart had been signed once a day on three out of eight days. Staff had not always signed to show when topical medicines had been applied.

MAR charts are legal documents. We had concerns about the way staff had dealt with the MAR charts. For

example, we found a number of instances where an entry had been altered, without explanation and so that the original entry was no longer legible. A code used to indicate why a medicine had not been given had not been explained. A forward slash had been written on the chart in place of a signature, with no explanation of what it meant. Holes punched in the MAR charts had obliterated parts of the names of some medicines.

The issues we found relating to medicines meant that we could not be sure that people were getting their medicines safely or as they had been prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked how the provider managed potential risks to people. We found that assessments of risks, such as risks relating to mobility, falls, nutrition and hydration, pressure ulcers and behaviour that challenged had been carried out and recorded in people's care records. However, we found that on Minton unit people and staff were at risk. This was because although there were charts that recorded any behaviour that challenged people the staff had not always followed the process as directed in people's care plans and risk assessments. Advice from the Dementia Intensive Support Team for one person was in the person's care records but had not been incorporated into the person's care plan. The Dementia Intensive Support Team advised that two staff always assisted the person with personal care. This was in their care plan and staff told us this was the case. However, other guidance, such as the way staff should approach personal care interventions and the importance of how they should position themselves to maintain their own safety had not been incorporated and staff were not aware of this.

We found that good practice guidance relating to infection prevention and control had not always been followed. An infection prevention and control action plan following an audit carried out by the local authority's Infection Prevention and Control Officer in December 2015 had stated 'Hoist slings were found hanging together… These slings were in use for more than one resident… This will lead to cross infection and potential spread of infection.' The timeframe to keep the slings in each person's bedroom was 'immediately.' An update on 3 June 2016 found this had not been actioned. During our visit we saw that a number of hoist slings were hanging together in a communal bathroom. We also saw that same sling was used for more than one person.

Staff told us they had been trained to respond to emergencies. One member of staff described the procedure they had been trained to follow in the event of a fire. They said the fire alarms were activated each week and staff were required to respond as they would if it was not a test. In the PIR the provider told us that 'Regular checks are carried out by maintenance - daily, weekly and monthly checks are carried out on all equipment and maintained to good working order.' This meant that the provider had procedures in place to manage the premises and equipment to keep people safe.

People told us they enjoyed living at Sutherlands Nursing Home and they said they felt safe. Comments included that the bedrooms were light and airy; that bedrooms had a door with good access to the gardens; and that each person could lock their door at night if they wanted to. Relatives also felt their family members were safe, with all areas being kept free from trip hazards and doors to outside having very low sills.

People who lived at the home told us that staff treated them well. They said, "Mostly staff are good," "No staff have treated me badly" and "[Staff are] very caring." A relative said, "They [staff] seem alright."

Staff told us they had undertaken training in safeguarding people from abuse and harm. They demonstrated

that they knew how to recognise if people were suffering harm and that they would report any incidents appropriately. One member of staff said, "I've done training in safeguarding [people from harm]. We report it in the [daily notes] and to the manager. We can call CQC if there are any problems. There are 'phone numbers in the nurses office and we [care staff] have access to that." One member of staff told us they would look up external agencies on the internet should they ever have need to report to anyone outside the home.

A senior member of staff explained the provider's recruitment procedure. They told us that staff completed an application form and checks, such as references, identity and a criminal record check were all sent for "before we start anybody." They said that the same procedure was followed for any volunteers who came to work at Sutherlands Nursing Home. Staff confirmed that all the required checks had been carried out before they started working at the home. This meant that the provider had a recruitment process in place which ensured that only staff who were suitable to work at this care home were employed.

Requires Improvement

Is the service effective?

Our findings

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.

One member of staff told us they had undertaken training relating to the MCA and DoLS. However, what they told us indicated that they had little understanding of the principles of the Act. They told us, "[People living in the home] have capacity. We give them choices and ask them what they like." Another member of staff said they had not received this training.

Care records for one person included an assessment of the person's mental capacity to make specific decisions. The decisions were about funding and about the person remaining at Sutherlands Nursing Home. A DoLS authorisation had been granted relating to these decisions. In the current medicines records folder we found a care plan for this person dated 13 February 2015. This stated that the GP had given consent that this person should be given their medicines covertly (without their knowledge) and had 'signed the MAR chart'. However, this was not available. Staff confirmed that the person received their medicines covertly. The provider found another care plan, written by the previous manager, which had been revised in March (or May, as the writing was not fully legible) 2016. This plan stated that the care objectives were 'To ensure medications are administered in [Name's] best interests.' We could not find a MCA assessment or DoLS application having been made relating to this decision. Nor was there any evidence of a best interests decision having been made on the person's behalf by anyone other than the previous manager. The provider told us the documents were on file. However, they could not be found.

This meant that the provider did not have sufficiently robust systems in place to ensure that staffs' knowledge and application of the MCA and DoLS enabled people to be cared for in a lawful way. There was a risk that people who were not able to make decisions for themselves would not have their rights protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a recognised method to assess people's nutrition and hydration needs and we saw that the assessments were in people's care records. People were weighed each month, or more often if they were

at risk of losing weight, and staff requested advice from the community dietician service when necessary. People who needed them had been prescribed dietary supplements by their GP. A healthcare professional told us that, "Usually my recommendations are being followed." They said they received timely referrals relating to people who were at risk of malnutrition and that no-one had lost weight once the recommendations had been made.

On the first day we visited we saw that lunch time was relaxed and people were not rushed. Tables were nicely set, with paper serviettes attractively folded and condiments available. In Minton unit five people ate in the dining room. They told us they enjoyed their meal and plates were empty when removed.

On the first day we visited, a relative made a general comment about meals. They said, "They [people who live at the home] need more vegetables [with their meals]." On the second day we visited we saw that the meal provided at lunchtime was neither nutritionally balanced nor healthy. People were given either beef or vegetable lasagne, with mashed potato and cheese sauce. There were no vegetables or salad. Dessert was trifle, consisting of jelly, custard and cream. One person was at risk of choking. Their care records stated they required a fortified pureed diet but they were given lasagne, which they could not eat. This meant they only ate a small amount of potato and sauce for their lunch. Their relative told us that this had also happened the previous week when the meal had been large pasta tubes. The relative said they showed this to a senior member of staff. Their family member had not been offered an alternative meal. Another person told us they were diabetic so had no dessert as there was no other choice besides trifle. This meant that people who needed a modified diet were not always provided with appropriate meals.

We noted that most people had access to drinks throughout the day so people who were able to could help themselves. One person told us, "They make a good cup of tea, spot on." However, the relative of a person who remained in bed told us that staff did not encourage their family member to drink enough. This person could drink independently, but the relative said there was never a drink left within reach. Care records in this person's room instructed staff to 'ensure [name] has drinks within reaching distance as [they are] able to take fluids independently.' In another person's care records we noted that staff were to 'encourage adequate fluid intake'. The manager agreed that the word 'adequate' was not helpful and did not provide staff with the information they needed to keep the person hydrated.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether staff had the knowledge and skills to do their job properly. A senior member of staff told us that all new staff received a thorough induction when they started working at the home. They said this consisted of two full days of training. New staff worked alongside more experienced staff until they felt confident to work alone. We met one new member of staff who confirmed they were working closely with an experienced colleague. Another member of staff told us, "I had an induction that included two days when I shadowed staff. I got more involved on the second day."

Staff told us that they had undertaken training in a range of topics relevant to their work. Topics included moving and handling; food hygiene; infection control; health and safety; fire safety; and privacy and dignity. The majority of training was carried out in-house by a senior member of staff. They told us they also made sure new staff were given the right information by the experienced staff they were shadowing. They carried out a 'dignity audit' to check that staff were putting their training into practice. We met a healthcare professional who provided training relating to tube feeding directly into the stomach. They told us they trained the nurses annually. Records of training showed that all except one member of night staff were up to date with their training. This member of night staff had not done any training since March 2012. The new

manager assured us they would rectify this.

However, staff did not always put their training into practice. For example, staff administering medicines, including registered nurses, had not recognised or dealt with any of the issues we found. On Minton unit every bedroom door had a sign that read 'My room', with a frame for a picture or photograph and a name plate which were both empty. Staff, including senior staff, had not recognised how confusing this could be for people who were living with dementia.

In the PIR, the provider wrote, 'Annual mandatory training and on-going supervision is carried out with all staff members'. One member of staff said they had a supervision session with their line manager about once a year. Other staff told us, and supervision records confirmed, that the majority of staff had not received supervision. Two staff had received one session each in the seven months of 2016 and seven staff had received one session each in June, August or December 2015. Staff told us they had not felt supported by the previous manager. However, several staff felt supported by the new manager even though they had only been in post for a few days.

Care records showed that people were supported to maintain their health by a range of healthcare professionals, such as the GP, community nurses, dietician, dentist and chiropodist. One person told us, "The doctors come here when I ask." Another person told us, "The dentist and hearing aid people come and visit me at the home." A relative told us, "Our [family member] has had physio[therapy] at the home today."

People who needed it also received support from the local Dementia Intensive Support Team. This team, made up of both health and social care professionals, provided advice and guidance to the staff, particularly about those people living with dementia who had episodes of behaviour that challenged themselves and others. This meant that people were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

In the PIR the provider told us that they made sure that 'the care and support provided to residents takes into account residents' preferences, respect for dignity, privacy and to allow our residents choice in all aspects of their care and needs.' However, we found this was not always the case.

People were given opportunities to make choices about some aspects of their daily lives. People who ate a regular diet made a choice the previous day of main course for their lunch. The manager told us that if people had changed their minds when the meal arrived, they would be offered an alternative. People were able to choose where they ate their meals. One person told us, "I like the lounge. I'm taken there when I want to, to have my meals. If not, I eat in my room." However, staff told us that people who needed a modified diet were not given choices as there was only one pureed meal.

People could not always choose what time they got up in the morning. For example, one person, who had been given their breakfast at 11am said, "I would prefer to be up earlier." One member of staff told us "It's hard to work out who to do first. We make the plan each day depending on what the night staff have done." They said that when they went in to each person in the morning, that person could choose to get up then or wait till later. This showed us that people had not been able to request when they would normally like to get up. On the second day we visited, they told us that they "had finished [assisting people to get up] by 12."

Some staff knew some of the people they were looking after well. One member of staff told us about one person and was able to detail the person's background and interests, family input and health needs. People told us that staff knew their individual needs in respect of the care they needed. A healthcare professional told us, "I'm quite impressed: the nurses really know their patients." However we found that care staff did not always know about people's medical needs. We saw that one person had very 'sticky' eyes. Care staff were unaware that this person had a problem with their eyes and had been prescribed eye drops to be used when required. They told us the nurses dealt with this. However, they had not alerted the nurse that the person's eyes needed attention.

All except one of the people we spoke with had nothing but praise for the staff. The caring attitude of the staff was seen as one of the strengths of the home. People and their relatives used words such as "caring", "patient", "helpful" and "compassionate" when they described the staff. They said, "They are all very courteous and nice", "They are very thoughtful and very caring", "They do care" and "Most staff are really nice and speak nicely to [family member]." A healthcare professional said, "All the nurses are very helpful and really caring…they've been really professional." Another healthcare professional told us, "They [staff] appear responsive and caring….the care seems good." People and their relatives included ancillary staff, such as the chef and the gardener/handyman in their praise of the staff. Only one person voiced any concerns. They told us that one member of staff had not been very kind to them.

The new manager said the staff really cared. As an example, they told us that staff were very upset by how distressed one person was who was newly admitted to the home. In regard to this person, a professional from the Dementia Intensive Support Team told us that the manager "had seemed genuinely concerned"

when discussing this person.

During our visits we saw some warm and caring interactions between staff and people who lived at the home and that people were comfortable with the staff. There was some light-hearted banter between them and staff showed they cared about the people they were looking after. We saw that staff spoke kindly to people and offered assistance, such as with cutting up food, when it was needed. The activities member of staff very patiently supported and engaged one person on Minton unit who constantly interrupted verbally and physically for attention. This provided a quiet, calming influence.

People were treated with respect for their privacy and dignity. One member of staff told us, "It's [privacy, dignity and respect] about how you talk to [people]. I talk to people like I'm talking to my mum." We saw that staff knocked on people's bedroom doors and, when appropriate, waited for a response before entering. Staff told us they ensured curtains were closed and doors shut before personal care was provided. A senior member of staff told us they trained all staff in respecting privacy and dignity and carried out audits to ensure that staff were putting their training into practice. In the notes from an audit in February 2016, the senior staff member had written, 'Carers spoke clearly and politely to each resident, giving them time to consent before tasks were carried out.' Staff explained that the call system in each person's bedroom also allowed staff to light an indicator outside the bedroom door, which showed that the person was receiving personal care. We saw that these were used and the dignity audit confirmed that staff had 'engaged the in-attendance light to prevent anyone else entering.'

We saw that personal care was offered quietly and discreetly. The manager confirmed that staff used dignified phrases, such as "Shall I take you to your room?" when suggesting a person might need assistance with their personal care. One member of staff said they always made a note of what each new person liked to be called. The dignity audit stated 'Residents were each addressed by their preferred name.' However, not all staff respected people's preferred name. A relative told us that some staff shortened their family member's name. Due to their dementia, their family member would not understand this as their name.

People told us there was no discrimination in the care home, on any grounds. One person who was not born in the UK told us that staff went out of their way to make certain they felt at home.

People were supported and encouraged to maintain contact with family and friends. One person told us they did not get many visitors but they had a mobile phone "so I can keep in touch." People and their relatives felt that visitors were made welcome and could visit at any time. One of the lounges, which people rarely used, had a kitchenette where visitors knew they could make a drink and have a piece of cake.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider wrote, 'Pre-admission assessments are carried out to ensure all needs of the individual can be met.' We found these assessments in people's care records. The provider also wrote that one of the actions they took to ensure the service was responsive was 'Ensuring that care plans properly reflect the care needs of residents." However, we found that care plans did not always reflect people's needs .

The manager told us they had already identified that care plans and the associated risk assessments, which had been developed from the pre-admission assessments, needed to be updated and improved. They said that care plans were "absolutely horrendous." The provider made us aware that at the time of the inspection they were in the process of transitioning from a paper-based to an electronic care records system. The provider said they were moving to a paperless system "to provide better managerial control over care and records." Nevertheless, in spite of the transition, care plans and risk assessments should have been kept up to date to give staff current guidance to meet people's needs.

We found that information in care plans and guidance for staff on how to provide an individual's care varied between people. One person's history and the work they used to do had been used effectively within the care plan as a possible explanation of their current behaviour. For another person, there was no information about them or their interests before they came into the home, which could have been used to redirect their behaviour. On the first day we visited we discussed with the manager that for one person, whose mouth looked swollen and sore, there was no care plan in place relating to this aspect of their care. There was no evidence that mouth care was being provided.

For some people information and guidance in their care plan was incomplete or out of date. In one person's care plan we found that where people experienced behaviours which could challenge others this had been recorded. However, there was no guidance for staff on what the most appropriate response was, what action they needed to take or any calming or distraction measures. This meant that the responses to people's care needs would not be as safe, caring or responsive as they could have been. A 'behavioural chart' showed that staff had been injured when they had been supporting the person with personal care.

Some of the language used in the care plans did not give sufficient detail for staff to be able to provide the appropriate level of care. For example, words such as 'adequate', 'aggressive', unfavourable situations' and 'threatening' were all open to each member of staff's own interpretation. In one person's care plan staff were instructed to 'observe for any non-verbal signs of distress'. There was no further guidance as to how this might manifest for this person.

A healthcare professional told us that the care plan relating to the aspect of a person's care that they were involved with had not been implemented "as well as you would expect."

Some charts were in use to record individual aspects of people's care. These included food and fluid intake/output charts, repositioning charts and charts to record behaviour. We found that these had not all been completed in a way that would fulfil their purpose, which was to provide detailed information to direct

and monitor the care provided. A healthcare professional commented that "Sometimes there's a problem finding notes and the charts are incomplete."

A repositioning chart for one person gave no indication to staff as to how often the person should be assisted to change their position. Their care plan stated that the person should change their position four to six hourly. This person did not get out of bed, and needed staff assistance with repositioning at all times. Records relating to pressure area care showed that this person had developed two sores in April 2016, which were still requiring dressings at the time of our visit. We found that, according to the records, the person's care plan had not been followed because the records showed that this person had not been assisted to reposition for 15 hours and seven hours on consecutive days. This would have increased the risk of further tissue damage.

Behavioural charts did not include a record of the time incidents had taken place. This showed that staff lacked an understanding that for some people living with dementia the time of day could be a critical factor in their actions. This information should have been used to direct staffs' responses. One person's care plan had contradictory information, stating in one part that the person needed 'hourly observations when alone in their room' and two hourly in another part. Another person's care plan had not been followed. A chart recording an aspect of this person's medical condition had no entries from 3 to 13 August 2016 inclusive. Staff had been instructed to call the GP if there were no entries for three days but this had not been done. We reported this to the manager.

One member of staff told us that the 'handovers' between staff teams were "a good way for staff to have up to date information about the people they were caring for." However, staff told us that during handover they had been told that one person, who was unwashed and in their nightclothes, had "had a difficult night". They said they were leaving them to "relax". We looked at the handover sheet for the previous night and there were no details of any issues overnight and there was no information in the daily notes about the person. The record stated that the person had 'slept well'. This meant that the information in verbal and written handovers was contradictory and could have had a negative impact on the care people were provided with.

We saw the activities coordinator working on Minton unit. They tried to work with two people on an individual basis but were constantly interrupted by a third person who claimed much of their attention. This was because care staff were busy in other people's bedrooms providing personal care so were not able to give this person the support they needed. People had not always received personal care or assistance to get up when they would have preferred. Several people told us staff did not have enough time to talk to them.

None of the people we spoke with could recall being asked formally to be involved in compiling their care plan but they told us that staff asked them about their care. One relative said they had been involved in their family member's care plan. They also told us that a review was coming up soon and that one of the person's family would be there. Another relative told us, "We talk about it [the care plan] and they [staff] make changes. I read it and sign it." People knew that there was a folder in their room with some care information, which they and their relatives could look at, at any time. Relatives said they only had to ask a member of staff to be able to look at their family member's full care plan. This meant that people and their relatives had some say in the care provided to people.

The manager and the provider told us that the provider was in the process of introducing an electronic care planning system. In the PIR the provider wrote, 'With this process it will reduce nursing time with administrative work releasing more time to care, which in turn will assist in a safer service with the nurses spending more time with residents and carers.'

In the PIR, the provider told us about their aspirations for the home and what they planned for the next 12 months. They wrote, 'Continuing to develop a home environment that is engaging and stimulating and moving away from a task based approach.' Two 'activities coordinators' had recently been appointed to fulfil the provider's aspirations. One told us that once they had taken pre-booked holidays, they would be covering seven days a week between them. The activities member of staff we spoke with was full of enthusiasm and great ideas for how the level of activity and stimulation for people could be provided. They recognised that individual activities, especially for those people who did not leave their bedrooms were as important as group activities, outings and entertainments. They talked about reading poetry or books, doing quizzes, doing people's nails and singing with people as examples of individual activities. They said that care staff were "very good" and made sure people staying in their rooms had their choice of television or radio programme.

The activities member of staff told us that part of their role was to be involved with assisting people with their meals. They said they used this as an activity and an opportunity to get to know people. People told us "I like the chats with the staff at mealtimes. They get to know you and you get to know them when they're helping you to eat", "The event ladies are very good. They have one-to-ones with me like quizzes to keep my brain active…everyone is different and they adjust their activity to suit" and, "We play bingo and the lady comes in to read to me." Another person told us that they had been invited to a wedding but were not able to go. They said, "The activity coordinator is making me a corsage to wear on the day." A relative told us that one person had been very distressed and very vocal, which some other people had found upsetting. The activity member of staff had found this person an activity that they really enjoyed and could do on their own at any time. They had become much more settled and much happier.

Each person in the bedrooms downstairs had a small area of garden outside the door from their room that accessed the gardens or courtyards. They told us that staff encouraged them to look after this patch if they wanted to, or the gardener supported them with this. One person told us, "I have bird feeders outside in my garden, which are my own." They explained that staff helped them to fill the feeders and the gardener looked after the flowers and bushes.

The provider had a complaints policy and procedure in place. We saw this in a folder in each person's room, in a brochure that people were given when they moved into the home. The procedure was not up to date as it named a manager who had left at least a year ago. It did not contain details of the local authority, which people could complain to if they did not want to approach the staff or manager. One of the people who lived at the home and another person's relative told us they had complained to the previous manager but their complaints had been dismissed. No complaints log was available during our visits so we could not check whether complaints had been recorded, responded to or addressed. A relative said they had raised an issue the previous week with a senior member of staff but the same issue had arisen on the day we visited. They said, "I keep telling them and telling them." From our discussions with the current manager we had confidence they would respond appropriately to complaints. One person told us they found their bed uncomfortable and not suited to their needs. The manager agreed to find them a more suitable bed.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 26 and 28 January 2015 we found that the quality of the service was not being effectively monitored. Effective systems were not in place to obtain and act upon the views of staff. Monthly provider visits had been carried out but no action plans had been drawn up to address areas requiring improvement. Only one medication audit had been found, which had been carried out six months before our inspection. This was a breach of regulation 10 Health and Social Care (Regulated Activities) Regulations 2014. The provider wrote to us and told us that staff would be 'reminded at induction and other training that the management of the home wishes to know their views on the service and areas where it can be improved.' They said 'staff are provided with regular supervision when their feedback on the service is sought' and 'staff views on the service is sought in the course of quality assurance visits.' They told us these actions would be completed by 5 June 2015.

During this inspection we found that the provider had not taken effective action and was still in breach of this regulation.

We found that staff views had not been sought, staff had not been offered regular supervision and the records of the quality assurance visits carried out in June and July 2016 showed that staff had not been asked for their views about the service.

There were no formal, effective systems in place to monitor the quality of the service being provided. For example, we asked to be shown how medicine management was audited. In the PIR, the provider had written, 'medication audits are on-going…monthly'. During our visit the provider told us that no audits had been carried out. The provider said that 'provider visits' were carried out by their representative to audit and monitor the quality of the service. The records of the visits carried out in June and July 2016 showed that there was no formal structure to the visits and no set list of topics or areas of care to be audited. Following the inspection, the provider sent us a copy of the agenda for these visits. The provider stated, "The provider's visits are carried out to an agenda which gives it a formal structure. The agenda is structured to cover all aspects of the service over time. For this reason, it will not audit the same elements on every occasion though certain key elements of the service will be subject to more frequent audits than others." Nevertheless, from the records we were shown, we saw that issues of concern had not been followed up the following month, which meant that there was no way of measuring if the service had improved or declined. At the June visit, the provider's representative asked two people for their views about the service provided to them. No people's views were sought at the July visit.

Almost all comments on the 'provider visit' records were about areas that needed improvement. However, there was no action plan developed from the report, no indication of who was responsible for ensuring the shortfalls were addressed and no timescale for when the issues would be rectified. Some of the areas identified by the provider's representative were areas that we identified at this inspection. This confirmed that the provider's system was not effective in driving improvement. It also showed that the system had failed to identify a number of other concerns found during our inspection.

Audits had been carried out by the local authority's Infection Prevention and Control Officer and by the commissioning authority in December 2015 and January 2016 respectively. Follow-up visits by both teams had shown that the provider had not used the information from the audits to drive improvements and a number of the shortfalls identified had not been addressed.

During our discussions with the provider, we gave them the opportunity to send us further evidence relating to the way they monitored and improved the quality of the service. We did not receive any further information from them.

This meant that there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify CQC about certain changes, events and incidents affecting their service or the people who use it. Our discussions with the provider and records kept in the home showed that CQC had not always been notified of safeguarding issues that had been raised with the local authority's safeguarding team. The management team told us they had not been aware of this requirement.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Records were not always completed as required. For example, one person's 'topical creams chart' stated 'apply to sore areas after pad change'. We saw that the chart had been completed once a day for six days out of the eight days prior to and including the second day we visited. Care plans were not always up to date and MAR charts were not always completed correctly and accurately.

On their website, the provider advertised that there was an active residents committee. However, there was no evidence of this at the home and at our first visit people and their relatives told us they had not been to any residents' or relatives' meetings. Following the inspection the provider told us that although they were aware that such meetings were held, the minutes from those meetings were not available. They had located a poster and emails to families relating to a meeting that had been planned to take place on 28 November 2015. We saw that the new manager had invited relatives to meet them on the following Saturday. At our second visit they said they had met several families and it had been a very constructive meeting. The manager said minutes from the meeting would be made available.

There was no registered manager in post. The manager at the time of our inspection had taken up their post 10 days before our first visit. At our first visit they told us, "I think it's a lovely home… I know it needs some work." At our second visit they said, "There's an awful lot to do, in every aspect of this home." However, they did not seem fazed by the prospect and told us that there would be "great improvements" in six months' time. They said they would be applying to register as the manager.

People, their relatives and the staff were very impressed with the manager, even though they had only been in post for a few days. She had been very visible around the home and everyone found her to be approachable. A senior member of staff said, "The new [manager] is very nice, with a very nice manner. Residents, relatives and staff have all taken to her. I'm very impressed." The manager told us they spent time at least twice a day walking round the home and talking to the people who lived there. People said, "The new manager here is lovely. I have seen her every day" and "The new manager is very pleasant and very patient." A relative told us, "I will speak to this manager – she says her door is always open." A member of staff told us they felt the new manager had listened to them, which had improved the quality of life for one person. They said, "The new manager is lovely, really approachable. I had a query about a person's food and spoke to her. She said that we could change the person's food from soft to puree for main meals on a trial

basis."

Staff told us they enjoyed working at the home. They said, "It's very nice. I wouldn't have stayed so long if I didn't like it." "Staff are usually happy – you can trust them" and "I really enjoy it. It's a lovely place. The residents are always happy and cheerful."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified the CQC of allegations of abuse in relation to people who used the service. Regulation 18(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were not always protected against the risks of their care being delivered without valid and lawful consent. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people who used the service were not always met. Regulation 14(1) (2)