Four Seasons (No 9) Limited

Bon Accord

Inspection report

79-81 Church Road
Hove
East Sussex
BN3 4BB

Tel: 01273721120
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6, 7 and 15 February 2017. The inspection was brought forward due to information of concern that we had received from relatives, the local authority and the Clinical Commissioning group (CCG) due to information of concern. The first and third days of inspection were unannounced which meant that the provider, registered manager and staff were not expecting us.

Bon Accord is a nursing home providing accommodation for people who are living with dementia and who require support with their nursing and personal care needs. It is registered to accommodate a maximum of 41 people, as some of the rooms are large enough for dual occupancy. However, rooms had been converted and were single occupancy; therefore the provider only accommodated a maximum of 33 people. On the first day of our inspection there were 31 people living in the home. On the second day of our inspection there were 30 and on the third day of our inspection there were 29 people living in the home. This was due to deaths that had occurred. The home is a large property situated in Hove, East Sussex; It has three communal lounges, two dining rooms and a garden.

The home is owned by Four Seasons (No9) Limited, which is part of a large, privately owned, national corporate provider called Four Seasons. Four Seasons (No9) Limited own a further three care homes in England. The management team consisted of a registered manager and senior care assistants. A registered manager is a '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. On the second day of inspection the registered manager resigned with immediate effect.

The overall rating for Bon Accord is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the providers' registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were systematic failings, poor leadership and management and ineffective governance that meant

that people did not always receive good quality, safe care. Quality assurance processes, whilst sometimes recognising that there had been inadequate care, were not robust and had failed to adequately improve the care that people received. There had been on-going, long-standing issues with regard to peoples' access to medicines that had not been suitably managed or improved. The registered manager, who was new in post, was not suitably supported to ensure that they were able to assess, monitor and improve the care people received. The provider had failed to ensure that people received a good quality service that they had a right to expect. This was echoed within a comment made by a relative, who told us, "The manager is so stretched I blame Four Seasons for not giving him the support he needs to do the job properly". There was low staff morale, staff were unhappy and felt unsupported and this was embedded in most staffs' practice and in the culture of the home.

There was a lack of assessments to assess risks to peoples' well-being. People were at risk of social isolation and were not adequately monitored to ensure their safety, nor did they have access to call bells to enable them to summon assistance when needed. People did not receive safe care and there were wide-spread concerns with regard to their access to prescribed medicines. The provider had failed to ensure that people were provided with medicines to maintain their health and well-being. People had consistently not had their prescribed medicines for several days and this had a direct, negative impact on their health and well-being.

People did not always receive support to access healthcare that was responsive to their needs. A relative told us, "We weren't happy, X had a high temperature for a few days, and they were coughing when they were drinking. Eventually my relative had to insist that they call the Doctor which they did and X had got a chest infection and was given penicillin. They hadn't picked up on it and in the end X had to go to hospital and was diagnosed with pneumonia".

Some people had lost significant amounts of weight, whilst this had been monitored; it was not apparent what action had been taken in response. Food and fluid charts lacked detail to identify if people had been continually refusing food and not all people had access to supplements or fortified food to increase their calorie intake. Not all people received appropriate support to eat and drink. A relative told us, I'm not confident that they would give X the attention they need to make sure they eat properly so I come in everyday to feed them and make sure they have fluids too".

People were not always assisted to move and position in a safe manner. Observations raised concerns about some staffs' practice. People were not always protected from harm and abuse. Some people, who were living with dementia, sometimes displayed behaviour that challenged others. Observations of staff practice when assisting people during times of distress, as well as records, raised concerns with regard to the use of restraint. Staff had not received training in how to deal with such situations and as a result asked a CQC inspector of the correct way to do this. There was a lack of understanding with regard to circumstances that could be constituted as abuse. The registered manager had failed to identify these and medication errors as safeguarding incidents and had not always reported the incidents to the local authority for consideration under safeguarding guidance.

There was a lack of stimulation and interaction with people, other than when they received support with their basic care needs. There were no meaningful activities for people to participate in and people spent their time in their beds or armchairs, sleeping or walking around the home looking for something to occupy their time. Staff did not take time to spend with people, other than when providing support to people who required one-to-one assistance from staff. Some people were socially isolated in their rooms. One person, whose room was on the upper floor of the home, and who had no access to a call bell, was continually crying and calling for help and was showing signs of apparent anxiety. There were no measures in place to assess the risk to the person or to prompt staff to undertake regular checks to ensure the person's well-

being.

Records, to document peoples' needs and preferences were in place. However, although these contained information to inform staffs' practice, such as how to move and position the person in a safe manner. Observations and discussions with staff raised concerns with regard to their implementation. People and relatives told us that they had not been involved in the review of the care plans. Comments included, "It used to happen in the early days but everything is just the same now" and "No we've not seen one at all and we've not had any reviews".

People were not always treated with dignity and their privacy was not always maintained. Most staff treated people with respect. However, observations of some staffs' practices demonstrated that they did not maintain peoples' privacy when discussing sensitive information. Observations showed staff discussing peoples' confidential healthcare needs as well as organisational information in front of other people and relatives. Peoples' privacy was not always maintained when they were having their medicines. One person was assisted to have cream applied to their legs in the main corridor whilst another person was assisted to have their blood glucose levels tested and an injection administered whilst sitting at the dining table with other people.

Assessments to determine the required staffing levels to meet peoples' needs were not always completed and as a result there was a risk that the tools that the provider used to determine the required staffing levels were out-of-date and did not meet peoples' current needs. Observations showed that staffing levels were not effective during peak periods and when people required assistance from staff they were not always available. A significant amount of staff had left and there had been an influx of new care and nursing staff. Existing staff told us that new staff often lacked the skills and experience required to enable them to carry out their roles and that their inductions into their roles were not effective. Some staff held roles which enabled them to carry out certain nursing tasks. However, there were concerns, due to the high levels of agency registered nurses used, that these staff were often unsupervised and not adequately supported. Concerns had been raised with regard to the possible blurring of boundaries between the responsibilities and duties between these staff and registered nurses.

People were not always asked their consent before being assisted. Practice and the lack of records confirmed that here was a lack of understanding in relation to the practical application of mental capacity assessments (MCA) and the deprivation of liberty safeguards (DoLS) and some decisions were made by people who were legally unable to make decisions on peoples' behalves.
Not all people had a positive dining experience. People were provided with choice with regard to the menu options and told us that they enjoyed the food. Observations showed that most staff demonstrated good practice when assisting people to eat and drink. However, other staff did not interact with people, explain their actions or support people at a suitable pace.

Records were not always completed in their entirety to demonstrate staffs' practice. For example, when people required assistance with moving and positioning staff did not always complete the records to clearly show when and how the person had been repositioned. This meant that staff were not always provided with information to enable them to effectively carry out their role. Registered nurses did not complete records to monitor the on-going health needs of people and as a result it was unclear how peoples' conditions had been monitored and if they had received the appropriate treatment. There were ineffective systems in place to safely store historical records relating to peoples' care. There was not an effective archive system in place to enable records, which were no longer currently in use, to be stored in such a way that would enable them to be easily retrieved.

Due to the level of concerns with regard to peoples' safety, subsequent to the inspection safeguarding alerts were raised with the local authority.

We found a number of serious breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Inadequate

The home was not safe.

Peoples' safety was at risk. Medicines were not managed appropriately and people had often been without their medicines for a number of days.

People were not adequately protected from abuse or harm. There were insufficient staff at peak times and staff were not appropriately deployed to meet peoples' individual needs.

Risks to peoples' health and welfare were not always assessed or identified. Peoples' freedom was sometimes unnecessarily restricted by staff who had not received training or guidance in the appropriate use of dealing with behaviours that challenged others.

Is the service effective?

Inadequate

The home was not effective.

There was a lack of support, supervision and training for staff to enable them to meet peoples' specific needs and provide effective care.

People were asked their consent for day-to-day decisions. However, peoples' capacity to give consent had not always been assessed and relevant people were not always involved in the decision making process when people lacked the capacity to give their consent.

Most people were supported to eat and drink sufficient quantities to maintain their health. However, some people, who required additional support to maintain their nutrition, had not always received the appropriate support. People had a varied dining experience.

Is the service caring?

Inadequate

The home was not caring.

Peoples' privacy was not consistently maintained. People were

not always treated with dignity. There were a lack of systems in place to enable people to make their wishes known in relation to end of life care.

There was mixed feedback and observations of staffs' practice with regard to their caring nature. Most observations showed that staff were kind and caring.

People and their relatives were involved in day-to-day decisions that affected their lives.

Is the service responsive?

Inadequate

The home was not responsive.

People did not always receive person-centred care that met their individual needs.

There was a lack of stimulation and interaction with people and people were at risk of social isolation.

People had access to a complaints policy, complaints were investigated according to the providers' policy. Relatives and healthcare professionals were encouraged to provide feedback.

Is the service well-led?

Inadequate

The home was not well-led.

The home did not have a positive culture that ensured that people were treated as individuals.

There was a lack of strong leadership, management and strategic oversight of the home.

Despite a quality assurance process being in place to identify the shortfalls in the care provided. Appropriate, timely action had not been taken to resolve the issues that had been identified.

Bon Accord

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 checked 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 home under the Care Act 2014.

The inspection took place on 6, 7 and 15 February 2017. The first and third days of the inspection were unannounced. On the first day of the inspection the inspection team consisted of three 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 home. The inspection team on the second day of the inspection consisted of one inspector. On the third day of inspection there were two inspectors. The inspection was brought forward due to information of concern that we had received. On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this was because we were responding quickly to information of concern. Prior to the inspection we looked at information that had been shared with us by the local authority and Clinical Commissioning Group (CCG); we also looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with six people, six relatives, ten members of staff, a visiting healthcare practitioner, a healthcare professional and the registered manager. Following the inspection four healthcare professionals were contacted for their feedback. We reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for twelve people, medicine administration records (MAR), five staff records, quality assurance audits, incident reports and records relating to the management of the home. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experiences of people who could not talk with us. We observed care and support in the communal lounges, dining rooms and in peoples' own rooms during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The home was last inspected in April 2015, and received an overall rating of 'Good'.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "I don't have worries here. Yes I would tell them, any of them". Another person told us, "Yes happy and safe I am". However despite these positive comments we found areas of practice that put peoples' safety at significant risk and that required improvement.

Prior to the inspection concerns had been shared with us with regard to people not having access to their medicines. Records showed and staff confirmed that people had not always had access to their medicines. There were insufficient systems and processes to ensure that prescribed medicines were ordered on time and that they were monitored to ensure that sufficient stocks had been delivered and were available when people required them. Records of meeting minutes, in February 2016, involving a representative from the GP surgery, a pharmacist and a representative from the Clinical Commissioning Group (CCG) stated that there had, at that time, been long-standing issues, with regards to the management of medicines. It stated that people had not always received their medicines in a timely manner and that there had often been several days when people had been without their medicines. A further meeting in May 2016 identified that although some improvements had been made there were still on-going concerns.

A lack of permanent registered nurses and a high use of agency staff meant that the management of medicines lacked oversight and there was a lack of responsibility and accountability of medicines management. A relative told us, "They use a lot of agency nurses and I'm finding I have to keep chasing them about X's paracetamol". A healthcare professional told us, "It is disorganised and a complicated issue. From our point of view we're worried about the on-going care of our patients. Systems have broken down their end, medicine requests haven't been done or they haven't been given to the patient". This, in combination with the lack of effective systems to ensure safe medicines management meant that people were not receiving safe care and the provider had not done all that was reasonably practicable to mitigate such risks.

Observations showed people being supported to take their medicines during their lunch and drinks were available to enable people to take their medication comfortably. However, peoples' consent was not always gained when being supported to have their medicines. For example, one person was asked by a registered nurse if they could test the person's blood glucose levels and administer their injection. The person did not respond. Another member of staff, who appeared to know the person well, intervened and spoke gently to the person, offering them reassurance. However, the language that was used did not always demonstrate respect for the person. The member of staff advised the registered nurse, "Just do it or they'll get worse". The registered nurse then tested the person's blood glucose levels and an injection was administered without providing the person with time and the appropriate support to give their consent.

Records showed that staff were not always acting on instructions that were given by GPs. For example, one person, who had received end of life care, had been visited by their GP and staff had been informed that certain medicines which had been prescribed to the person should be stopped with immediate effect. However, records showed that registered nurses had continued to administer the medicines for a further five days. A relative told us about another example where medicines were not being administered in accordance with the prescribed instructions. They told us, "We were getting very concerned about how sleepy X was in

the mornings and being left until lunchtime before they got them up. We spoke to the GP who stopped one of the tablets, however they (registered nurses) still carried on giving it and in the end we had to get quite firm about it and after about two weeks they finally stopped giving it and now X is more alert and is up during the mornings".

Each person had a medicine administration record (MAR) which contained information on their medicines. The MAR contained guidance for staff to follow with regards to the administering of certain medicines such as tablets, however, lacked detail in relation to the administering of topical creams or patches. Guidance with regard to the application of patches stated that patches should be placed on alternate areas at each application. Staff were required to record on a body map the location of the patch to ensure that the patch could be applied to an alternative area when it was next applied. However, records showed that these had not always been completed and when this was raised with a registered nurse they told us that when they had attempted to change a patch on a person's body, they were unaware where the previous patch had been applied. Not recording the application of patches could potentially mean that patches were not applied to alternate areas as directed within the prescribing guidelines.

There were numerous examples of when people had not had their medicines due to insufficient stocks of medicines and the concerns with regard to safe medicines management were widespread. Records raised serious concerns with regards to medicines management and there were significant risks to peoples' safety. For example, records for one person showed that a prescribed medicine, to lower their blood pressure, had not been given for eight days. The reason why the medicine was not given was recorded on the MAR. This stated, 'none supplied this cycle'. There were no records to confirm that the person's blood pressure and condition had been monitored over this period to ensure their welfare. Records showed that four days after restarting their medicines, the person had a fall and sustained an injury to their ankle. The person had been admitted to hospital and required surgery. A safeguarding referral was made to the local authority due to our concerns that the missed medicines may have contributed to the person's fall.

Records for another person showed that throughout the 28 day cycle of medicines they had been without medication to treat high blood pressure, motion sickness and dementia for up to a period of 13 days. Care plan records informed staff that the medicines were 'essential', and stated, 'Staff to check all medicine is available. Failure to take the medication can result in adverse effects on their physical well-being'. Records, to document visiting healthcare professionals' visits, over the period of time when the person was not having their medicines, showed that there had been an adverse effect on the person. One entry stated, 'X has been unhappy and has had a fall'. Another entry several days later, still during the period when the person was not receiving their medicines, stated, 'X is low and confused and was found standing in their own incontinence'. The person had been visited by their GP. An entry made by the GP stated, 'X has had a fall, blood pressure is raised and they have not had their medicines for seven days'. Records did not show what action had been taken in response to the changes in the persons' condition or with regard to the lack of prescribed medicines.

Records for another person raised further concerns. The person was prescribed a medicine for a heart condition. Guidance for the medicines stated that the person's pulse should be taken before each administration and that if the pulse falls below a specified level then the medicine should not be given. Records, to monitor the person's pulse had not been completed on two occasions; however, records also showed that the person's medicine had been administered. This raised concerns as it was not clear if the person's pulse had been checked and the registered nurse had failed to complete the MAR, or if the person's pulse had not been monitored before their medicine was administered. Therefore the person was at risk as there was a potential that they were administered their medicine when it was not required.

On the first day of the inspection it was identified that several people had not received their medicines that morning. When this was raised with staff they explained that the medicines were not in stock and therefore there were no prescribed medicine for those people to take. Records showed that this related to medicines that had been prescribed to provide pain relief, diabetic medication, anti-coagulant and anti-depressant medicines. Observations showed that one person, who had been prescribed anti-depressant medicines, and who had not had their medicines that morning, showed signs of apparent anxiety and was observed to be crying throughout the day. On the first day of inspection the provider had seconded a registered nurse from one of their other homes to assist with medicines management. The registered nurse had identified which people had not had their medicines and had taken immediate action to ensure that these were ordered. However, on the second day of the inspection people still had not had their medicines as these were yet to be delivered.

Further observations raised concerns regarding the unsafe administering of medicines. Observations showed a registered nurse passing a person's prescribed medicines to the person's relative so that they could administer these to the person. The Nursing and Midwifery Council (NMC) standards for medicines management, state 'You must be certain of the identity of the patient to whom the medicine is to be administered'. It goes on to state, 'A registrant (in this case the registered nurse) is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task'. By not administering the medicine themselves the registered nurse was not certain that the person, for whom the medicine was prescribed, took their medicine. They did not delegate the administration of medicines to a person who they had deemed competent to carry out the task. By not following the NMC standards there was a risk that the person would not be given their medicines or that another person could be administered a medicine for which they were not prescribed.

On the third day of inspection it was evident that measures to improve the systems in place with regard to medicines management had been implemented. The registered nurse, and an acting manager, both of whom had been seconded from another home, had identified the root-cause of the long-standing concerns with regard to medicines management. Records confirmed that medicines had often not been available to people at the beginning of each medicine cycle. The National Institute for Health and Care Excellence (NICE) guidance, 'Managing medicines in care homes' provides guidance for providers to follow when administering medicines, it states, 'Care home providers should ensure that at least two members of the care home staff have the training and skills to order medicines', 'Care home providers should retain responsibility for ordering medicines from the GP practice' and 'Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly'. By not adhering to this guidance the provider was not following good practice in ensuring that people had access to prescribed medicines to maintain their health and wellbeing. The interim deputy manager and acting manager had started to introduce mechanisms to ensure that people had access to medicines. These included the interim deputy manager taking the lead with regard to medicines management to ensure that medicines would, in future, be ordered in a timely manner.

Records showed that people had not always had their medicines. When MARs from previous months were requested by CQC, to enable us to view and monitor medicines management over the past year, they were not always available and staff were unable to locate all of the archived records. This meant that it was not clear if people had been without their medicines for longer periods of time than was identified, as records were not always available to view. Missing signatures, in some peoples' MARs, raised serious concerns with regard to peoples' access to medicines. It was not always clear if people had received their medicines and staff had failed to complete the records or if medicines had not been administered to people. This raised

serious concerns about unsafe medication practices.

Although measures had been taken to improve the systems in place, prior to this there had been a lack of clinical oversight with regard to the management of medicines and a lack of action to identify and rectify the root-cause of the long-standing issue. There were systematic failings in the management of medicines to ensure that people were safe and had access to medicines which were prescribed to them to maintain their health and well-being.

Care records for people who had been assessed as being at risk of malnutrition showed that not all people had been weighed regularly nor had their food and fluid intake been monitored to ensure that they had sufficient quantities to eat and drink. Food and fluid records and associated care plans lacked information to inform staff of the optimum amounts of fluids to be prompted. Food and fluid charts had not always been completed correctly, nor totalled or analysed and there was a lack of oversight to ensure that appropriate action was taken if people were not having sufficient quantities to eat and drink. Not all people who had unintentionally lost significant amounts of weight, had their food and fluid intake monitored, neither were they prescribed supplements to increase their calorie intake.

Records showed that 11 out of the 12 people whose weight records we looked at had unintentionally lost significant amounts of weight. Two people had lost over eight kilograms each within a 6 month period. This showed that these people were at risk of being malnourished. Records did not show that appropriate action had been taken such as the fortifying of food or referrals to healthcare professionals for advice. When staff were asked what action had been taken they explained that food was fortified with cream and milk powers to increase calorie intake and a referral had been made to a dietician for one person, however, the lack of recording meant that this could not be confirmed. The registered manager had taken some measures to ensure some people had access to nutritional supplements. Observations raised concerns about some peoples' access to sufficient quantities of food and drink. Observations showed that some people, who spent their time in their room, could not always reach the drinks that had been placed on their tables and at times these were taken away without attempts by staff to encourage the person to drink. A relative told us, "I'm not confident that they would give X the attention they need to make sure X eats properly so I come in everyday to feed X and make sure they have fluids too".

The provider had not always taken measures to ensure that each person was assessed in relation to risks that they were exposed to. Risk assessments had been undertaken in relation to the risk of falls, mental health and physical health as well as behavioural risk assessments. However, not all risks that people were exposed to were identified or managed appropriately. One person was under the care of a tissue viability nurse (TVN). The TVN had visited the person and had identified that the person had moved into the home nine days previously with a skin wound. A risk assessment, which identified risks to the person's safety with regard to moving and positioning, their nutrition and susceptibility to developing wounds had not been undertaken. Within the records completed by the TVN they had advised staff, 'Complete a Waterlow risk assessment asap'. However, despite this instruction from the TVN nineteen days previously, a Waterlow risk assessment had still not been completed. Failure to follow health care guidance placed the person at increased risk of harm.

People had call bells in their rooms, however, observations showed that most call bells were not within peoples' reach and therefore they had no way of calling for assistance if needed. A relative told us, "X's call bell has not been connected for a long time now I don't know why X doesn't have one". When the registered manager was asked how people would call for assistance or use their call bells, they told us that due to peoples' mental capacity they would be unable to understand how to use their call bells, therefore staff undertook regular checks to ensure their safety. However, there was no process to assess the risk of not

being able to use a call bell whilst in their room alone and as a result there was no guidance for staff to follow to advise them of how frequently they should undertake checks on people to ensure their safety and wellbeing.

Risk assessments were in place that assessed peoples' mobility and moving and positioning requirements. However, observations of some staffs' practice raised concerns about the awareness and implementation of these risk assessments. People were not always supported safely when being assisted to move and position. Observations showed that people were sometimes being supported by staff that appeared not to have the relevant skills and knowledge to undertake this part of their role in a safe manner. We saw one person spent large amounts of time sitting in a wheelchair that was intended to be used as a wheelchair to transport a person from one location to another and therefore was not designed for a person to spend large amounts of time in. Other observations showed some people being transported in wheelchairs with their feet unsupported as staff did not ensure that foot plates were used and therefore there was risk of an injury occurring. One person, was sitting in a wheelchair, being supported by one member of staff and the acting manager, the acting manager was unaware of the person's needs and asked the member of staff how the person needed to be supported. The member of staff explained that they did not know and that staff usually assisted the person to stand and sit in the arm chair. However, when the acting manager checked the person's moving and positioning guidelines, it stated that the person required full assistance to use a hoist by two members of staff. There was a potential risk that the person could have been assisted to transfer in an unsafe manner.

Staff undertook an unsafe procedure as they placed their arms underneath a person's arms and assisted them to stand. This is known as a 'drag' lift. The 'drag' lift is any method of handling where the care worker places a hand or arm under the person's armpit. Use of this lift can result to damage of the spine, shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm (humerus) and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' Records for the person contained conflicting guidance, it stated, 'X remains at high risk of falls. X is unable to weight bear, needs full assistance from two carers and the Zimmer frame to mobilise short distances'. This guidance was not implemented and the person was assisted to transfer in an unsafe manner and there was a potential risk to the person's safety.

People were not receiving safe care and treatment. Inadequate medication management, unsafe moving and handling practice, failure to follow healthcare professional's advice and the assessment of risk placed people at serious risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had an understanding of safeguarding adults and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. One member of staff told us, "I would speak to the staff member if I found out they were mistreating someone. I would also let the manager know". However, staff did not always implement their knowledge in practice. We saw that one person had a bruise on their neck. Records showed that this had not been documented and therefore it was unclear of the cause of the bruise or if staff had recognised this and taken action to identify any cause. When this was brought to the attention of a member of the management team, immediate action was taken. A photograph of the bruise was taken and an incident record completed. There were further failures to recognise

safeguarding incidents. There had been several occasions when people had been without their medicines for sustained periods of time which may have resulted in an adverse effect on their well-being. The registered manager had failed to identify these as safeguarding incidents and had not always reported the incidents to the local authority for consideration under safeguarding guidance.

Concerns had been shared with us with regard to the use of restraint when people, who were living with dementia, displayed behaviours that challenged others. Observations during the inspection raised further concerns about peoples' safety in relation to the use of restraint. Records for one person stated, 'X shows intense fear at being touched and it could be related to X's past memories. X has a particular fear that a man is trying to attack them and therefore whenever possible assistance should be provided by a female'. The person was observed being restrained on their bed, by three members of staff, some of whom were male carers, whilst receiving assistance with their personal care needs. The person was showing signs of apparent anxiety and calling out for help. Although staff offered reassurance and explained their actions it was apparent that they were unaware of the guidelines in place in relation to the person's care to ensure their well-being. Records for the person did not show that mental capacity assessments had been undertaken with regard to the use of restraint. Subsequent to the inspection the provider had identified that they could no longer meet the person's needs and they were supported to move to another home. Records for another person contained an entry that stated, 'Five carers are to restrain X on the bed'. The provider did not have a policy on the use of restraint and no staff had received training to enable them to effectively support people who displayed behaviours that challenged. This was further confirmed when a member of staff asked the Inspector if they were right to hold down a person's arms to the side of their body when they displayed behaviours that challenged. This demonstrated that staff did not have awareness of how to support people appropriately.

People were not always protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not adequate staffing. The provider used a dependency tool to assess peoples' needs in relation to the type of support they needed and the level of staffing required to meet their needs. However, this was not always effective. Records showed that the assessments that informed the dependency tool were not always completed and therefore staffing levels were based on potentially inaccurate and outdated information. There were nine members of care staff, two of which provided one to one care for two people who had been assessed as requiring more support to meet their needs. There was one registered nurse and a care home assistant practitioner (CHAP), that assisted the nurse, on shift during the day. At night there were four members of care staff and one registered nurse. The registered manager and records confirmed that this was a consistent level of staffing.

Relatives and some staff told us that there were not enough staff. One relative told us, "If I ring the call bell for X, I can wait for up to half an hour sometimes before anyone comes. The weekends are not good and lots of the regular faces have left". When asked if they felt there were enough staff, one member of staff told us, "Not always". There were concerns with regard to the deployment and practice of staff in relation to their whereabouts in the home and in responding to peoples' needs. Observations of people on the upper floors showed that they were not sufficiently monitored by staff. On three occasions an Inspector had to find staff to ensure that one person received the support that they needed to ease their distress. There were further concerns for people who spent their time in the communal areas of the home. Other than staff that were providing one-to-one support to people, there was a lack of staff presence for other people in the communal lounge that required support. Observations showed that a visiting healthcare practitioner provided drinks for a group of people who were sitting in the communal lounge as there was no visible staff presence, they were also observed adding thickener to a person's drink, as the person had swallowing difficulties. This

posed a potential risk to the person's safety as the visiting healthcare practitioner was unaware of the person's swallowing assessment and had added the thickener without the relevant knowledge. Observations of the person, when the healthcare practitioner left the room to obtain drinks for other people, showed them to be coughing whilst attempting to have their drink. This posed a risk to the person's safety. One person indicated that they needed to use the toilet; the healthcare practitioner had to stop the treatment that they were providing to another person to find a member of staff.

There were further concerns with regard to there being sufficient staff to meet peoples' needs at peak times. For example, not all people were assisted with their personal care needs in a timely manner and several people were wearing their nightclothes and appeared not to have been supported with their personal care needs, by mid-morning, neither was it evident that people had requested to stay in their nightclothes. Records for people did not indicate the times that they preferred to be supported to get out of bed and supported with their personal care needs and peoples' cognitive and communication abilities meant that they were not always able to tell staff of their preferences. This observation was reinforced by a comment made by a member of staff to a member of the inspection team and further demonstrated that there were insufficient staffing levels to meet peoples' needs. The explained to the member of the inspection team that by 12 midday all people who wanted to get out of bed had been assisted to do so.

There had been changes in the staff team and a significant number of staff had left over previous months. The registered manager had ensured that agency staff were used to ensure that staffing levels were consistent. However, there was a high use of agency registered nurses used and as a result there was a lack of consistency, responsibility and accountability. A relative told us, "There's not enough of them they're so stretched and because of the agency staff, who don't know people, it all takes time to get to know someone so it just adds to the stress. The last six months the turnover has been tremendous. You feel that they try hard but they haven't got enough of the right staff". Another relative told us, "You do pick up how stressed the staff are sometimes, they do try their best".

Staffing levels and the deployment of staff were not sufficient and did not allow for people to receive safe, personalised and individualised care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Checks had been undertaken on the environment to ensure it was safe and people had individualised plans to inform staff of how to support them to evacuate the home in the event of an emergency. Accidents and incidents had been recorded in accordance with the providers' policy.

Inadequate

Is the service effective?

Our findings

There were mixed observations with regard to the competence of staff. Some staff had a clear understanding of supporting people living with dementia. However, others, whilst well meaning, struggled to engage with people or support them in an effective way. One member of staff told us, "It is not dementia friendly here anymore". Relatives provided mixed feedback with regard to staffs' competence. One relative told us, "I think you'd go a long way to find a more efficient home". Another relative told us, They perform very well, they are brilliant I'd say and always pleasant". Other relatives told us about how staff had failed to recognise when their relatives were unwell. We found areas of practice that required improvement.

There had been a large influx of new staff and existing staff told us that new carers and registered nurses did not always have the relevant skills, experience or competence. Staff told us that the skills mix of staff had not always been considered when shifts were planned and as a result there were occasions when there were too many new, inexperienced staff working, who were unaware of peoples' needs. A member of staff told us, "Staff are not trained, people here need staff that are trained. There are too many new staff. They take anyone here, if they can't speak English, if they've not done the job before, they come here. It's gone down, down, down". Observations of some staffs' practice raised concerns about how well they knew the people they were caring for. For example, a member of staff was assisting a person into a bedroom, they were warm and gentle in their approach, however, the member of staff was calling the person by the incorrect name and had not realised that the room they were attempting to support the person into, was not theirs. The person was heard calling, "Help me, help me, where am I going? I don't know what to do". This continued for a period of time, the member of staff assisted the person to lie onto a bed that was not theirs and explained that they would go and get the person a cup of tea. Once the member of staff had left the room, the person continued calling for help. Another member of staff, who appeared to know the person well, supported the person to go into the communal lounge.

Not all staff had received a thorough induction to enable them to have an awareness of the providers' policies and procedures as well as peoples' needs, preferences and conditions. Some staff had completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training for new care workers. The provider had introduced training for staff in the form of the dementia care framework; however, this was yet to be implemented. Records showed that staff had completed training which the provider considered essential. However, subsequent to the inspection, concerns with regard to the accuracy of the data in relation to staff training, had been raised with us by the provider. The provider told us that there had been some anomalies in the data in relation to some of the e-learning courses and as a result it was unclear which staff had received training and which had not. The provider had taken immediate action and corrected the data that they held and ensured that all staff had access to regular training to ensure that their skills and competence were up-to-date. Staff were not provided with training that was specific to the needs of people. For example, some people, due to living with dementia, displayed behaviours that challenged others. Records of staff meeting minutes showed that staff had requested training to enable them to deal with these situations and support people effectively. However, this was yet to be implemented.

Some staff told us that they felt unsupported and that they did not feel able to approach the registered manager for advice or guidance. Records showed that staff had received supervision regularly. The registered manager had recognised that the registered nurses required clinical supervision, such as regular competency checks of their practice to ensure that they were working effectively. Competency checks had been arranged, however, these were yet to be implemented in practice.

We were initially informed, on the first day of the inspection that there were two nurses working during each day shift, however, it was later identified that only one of these nurses was a registered nurse. The provider had implemented a programme to enable more experienced care staff, who had a minimum of 12 months experience and who held a Diploma level 2 in health and social care, to become a care home assistant practitioner (CHAP). This role enabled the CHAP to undertake tasks including, recognising and acting on changes in peoples' conditions, undertake wound care and prevention and medicines administration. However, although CHAPS had undertaken the providers' required 12 week training programme, there were concerns with regard to the monitoring of their practice, their responsibilities and the possible blurring of boundaries in relation to their role and that of the registered nurses. For example, medicine records showed that there were considerable gaps in the recording of when medicines were administered. This raised concerns as to whether people had been given their medicines or whether the CHAP, who had been administering the medicines, had failed to sign the MAR to show that it had been administered. When this was raised with the CHAP they told us that the people had been given their medicines but that they had failed to sign the MAR. Despite the providers' policy on the use of CHAPS stating that CHAPS needed to be supervised by registered nurses, the agency registered nurse, whom the CHAPS had been working alongside, had not identified the gaps in medication records and had therefore not questioned if people had received their medicines.

Guidance on the responsibilities of CHAPS stated that they could only provide care for pressure wounds that were classified as a category one or two. (A category one and two pressure wound relates to superficial damage as well as damage to the first two layers of the skin). However, concerns had been raised with us which related to a member of staff, who was not a registered nurse, treating and dressing a category four pressure wound. (A category 4 pressure wound is a full thickness tissue loss with exposed bone or tendon). This raised concerns with regard to the possible blurring of boundaries between a CHAP's role and that of a registered nurse. There were concerns, particularly due to the high use of agency registered nurses, that CHAPS did not receive the level of support and supervision that they required to ensure peoples' safety. When asked about the implementation of the CHAP's programme, a member of staff told us, "It doesn't really work, I don't like it. The nurse has to oversee and check, but that proves a problem with the agency nurses we have".

The provider had not ensured that all staff received appropriate support, training and professional development to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' health needs were assessed upon admission to the home and most people had access to external healthcare professionals when required. Records showed that people had access to GPs, opticians, speech and language therapists (SALT) and TVNs. However, there were concerns with regard to staffs' abilities to recognise when people were unwell and in need of medical assistance to ensure that people received additional healthcare treatment in a timely manner. A relative told us about an occurrence when their relative had been unwell and they had had to continually ask staff to contact the GP. They told us, "We weren't happy, X had a high temperature for a few days, and they were coughing when they were drinking. Eventually we insisted that they call the Doctor which they did and X had got a chest infection and was given penicillin. They hadn't picked up on it and in the end X had to go to hospital and was diagnosed with

pneumonia. Last week X had a mucky eye which they hadn't picked up on either. My relative told them X needed urgent eye care and it cleansing with sterile water. They did it and a prescription was done over the phone, but it was us that brought it to their attention". Records for another person showed that staff had recognised that the person's shoulder was red and swollen and the person had shown signs of pain. The GP had been contacted who had arranged for a non-urgent x-ray and had recommended that the person be given pain relief to manage their pain. When x-rayed, two weeks later, the person was found to have a dislocated shoulder. Medicine records showed that the person had not been offered pain relief, before or after their diagnosis, as advised by their GP. Records did not show that the person's pain had been monitored during this time to ensure that they were not experiencing discomfort as due to the person's cognitive ability they were unable to communicate their needs to staff. Not all people received safe care and treatment and there were concerns with regard to timely access to additional healthcare services. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that some mental capacity assessments had correctly assessed the person's ability to understand information, retain and weigh up the information and communicate their decision. However, the mental capacity assessments did not always relate to a specific decision and simply assessed the person as not having capacity due to the fact that they were living with dementia.

The registered manager had demonstrated some understanding of DoLS and had submitted DoLS applications. However, not all people, who were required to have a DoLS in place, had one. Records and staffs' understanding raised further concerns with regard to the processes in place to monitor DoLS applications and authorisations. For example, one person had been assessed by staff as not having capacity and an immediate urgent DoLS application had been made and authorised by the local authority. However, when the person's DoLS authorisation needed to be reassessed and renewed the person's capacity had been assessed when they were experiencing mental ill-health and staff had stated that the person lacked capacity to make a certain decision. When the person was assessed by a best interests assessor from the local authority, at a time when they were not experiencing any symptoms from their mental ill-health, they were deemed as having capacity to make decisions and the DoLS authorisation was denied. However staff told us that the person was subject to a DoLS authorisation and records confirmed this. This raised concerns as to the interpretation and understanding of DoLS and as a result the person was being deprived of their liberty unlawfully.

Observations identified that some people had bed rails and lap belts in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where peoples' movement is restricted, this could be seen as restraint. Bed rails and lap belts are implemented for peoples' safety but do restrict movement. Observations of one person showed that staff had demonstrated good practice as they had identified and implemented the least restrictive practice. A low profile bed and a sensor mat were used to ensure the person's safety whilst they were in bed. However, the person used a lap belt to ensure their safety whilst they used a wheelchair. There were no records in place that had assessed the person's capacity to determine if they had capacity to be involved in the decision. Instead, the person's relative had signed the consent form for the use of the lap

belt. When the registered manager was asked for the documentation that confirmed that the person making the decision on the person's behalf was legally able to do so, they explained that this documentation had not been seen. Further records, for other people, showed that the registered manager had involved peoples' lasting powers of attorney or next of kin to make decisions on peoples' behalves. However, the registered manager had not seen nor held a copy of the lasting power of attorney and therefore was unable to confirm that people involved in decisions affecting peoples' care had a legal right to make decisions on their behalf.

Care and treatment of people must only be provided with the consent of the relevant person. Decisions for some people had been made by someone who was potentially legally unable to make those decisions. As a result some peoples' movement was restricted. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' communication needs were assessed and met. Observations of staffs' interactions with people showed most staff adapted their communication style to meet peoples' needs. Peoples' communication needs had been assessed when they had first moved into the home and these had been reviewed regularly. Observations showed people wearing communication aids such as glasses and hearing aids. There were plans to improve the communication aids that were available for people to use to increase their understanding. A recent audit of the dining experience people had showed that it had been identified that photographs and pictures of food should be used, in conjunction with the written menu, to increase people's understanding of the choices available to them.

Inadequate

Is the service caring?

Our findings

We saw that most staff were kind, caring and positive. Warm relationships had developed between some people and staff. There was mixed feedback with regard to the caring nature of staff. One person told us, "Everything is alright so far I quite like it here. It's a happy place really". One relative told us, "They are polite without being overpowering, just naturally polite. They are a terrific lot". Another relative told us, "I've no complaints other than the agency staff are not as caring". Despite some positive comments we found areas of concern regarding the care people received.

Observations showed that some staff explained their actions, gained peoples' consent and supported people according to their needs and preferences. Some staff were observed talking to people about the recent football scores or peoples' relatives and were observed guiding people around the building by holding their hands or having a gentle arm around their shoulders to reassure them. One member of staff was assisting a person to have their lunch and was overheard saying, "Hello X, I've got a napkin here to protect your pretty clothes". In these instances carers were calm and did not rush people and demonstrated patience and kindness. However, not all people were treated in a respectful or dignified manner.

The provider had a statement within peoples' records that were kept in their rooms and which were regularly accessed by members of staff. This stated, 'Bon Accord is the residents' home, we are all guests in their home. We need to respect their home the way we want our homes to be respected'. However, this was not always implemented in practice. We saw some staff did not explain their actions to people or offer reassurance when supporting them. Staff did not always ensure that peoples' privacy and dignity was maintained. Staff did not always knock on peoples' bedroom doors before entering their rooms and therefore did not demonstrate respect for their personal space. One person was being assisted to transfer from a wheelchair to an armchair, staff did not explain or communicate their actions whilst the person was being transferred to reassure them of what was about to happen. This did not demonstrate respect for the person. Another person was being supported to use a hoist. Staff demonstrated good practice by offering explanations to the person and involving them in the manoeuvre, however, did not recognise that the person's clothes had been caught in the hoist sling and their undergarments were displayed.

A relative told us of their concerns in relation to people having their care needs met and of their experience of how a person's dignity was not maintained. They told us, "I had to get quite angry. X's nails were black. I've even got a bowl of water and a brush and scrubbed them myself. I was going to call in the chiropodist they were so bad and the manager said it's not the nurses' job here to do that. I told them it jolly well was the job of them here to make sure X's nails are clean and tidy". Observations showed staff sometimes called across the room to people or staff in relation to peoples' conditions. For example, when supporting one person in the communal dining room, who had refused to eat their lunch, a member of staff called across the room to another member of staff explaining that the person was unwell and needed to go back into the lounge. Another observation showed a member of staff calling across the room to a person who was eating their lunch, they were overheard calling, "Swallow what's in your mouth". This did not demonstrate dignified care. One of the communal lounges had an access door to the back garden where staff could access the external laundry room and the designated smoking area. Staff were observed, continually using the door,

which was slammed shut and made a loud noise, to exit the home. This did not demonstrate respect for peoples' home or recreational space.

Peoples' privacy and dignity was not always maintained whist they were being supported to have their medicines. Observations showed one person was supported to have cream applied to their legs whilst they were in a communal corridor. Another person was assisted to have their blood glucose levels checked and an injection administered whilst they were sitting with other people at the dining table.

Information held about people was kept confidential, records were stored in locked cupboards and offices. However, observations of staffs' interactions and practice raised concerns over peoples' privacy and dignity. Staff were observed discussing peoples' confidential healthcare needs and conditions in front of other people and relatives in the main communal lounge. Other conversations, about organisational issues, were also discussed in front of people and relatives.

People were not always respected or treated in a dignified way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to remain at the home and were supported until the end of their life. The registered manager explained that when people were receiving end of life care that they liaised with the local hospice to ensure that people were provided with good end of life care. There were plans for staff to receive end of life care training, however, this had not yet been implemented. According to the Social Care Institute for Excellence (SCIE) people with dementia should be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advise that providers' of homes also need to ensure that they are prepared for situations and do their best to ensure that they know, document and meet the person's wishes at the end of their life. Advanced care plans were not in place for the people living at the home, these were only devised when someone was nearing the end of their life. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time. Records for one person showed that an end of life care plan had been devised within the days leading up to the person's death. However, due to the fact that the end of life care plan was not devised until this time the person was unable to contribute and make their feelings known. Records confirmed that there were no entries that documented the person's death or factors leading up to this. The lack of advanced care plans and the lack of recording with regards to the person's death were areas of practice in need of improvement.

People were encouraged to maintain relationships with their family and friends. People were able to have visitors to the home and observations showed that they were welcomed. Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

People were involved in day-to-day decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home. Residents' and relatives' meetings had taken place to enable people and relatives to voice their opinions and to enable them to be kept informed with regard to the running of the home. The registered manager recognised that people might need additional support to be involved in their care, they had involved peoples' relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Inadequate

Is the service responsive?

Our findings

Peoples' needs were assessed when they first moved into the home. Care plans documented peoples' needs and preferences and provided guidance for staff to follow to enable them to meet peoples' needs. However, relatives told us that they had not been involved in the review of care plans and records confirmed this. A relative told us, "It used to happen in the early days but everything is just the same now". We found areas of practice that required improvement as people were not receiving personalised care.

Some relatives were complimentary about the responsiveness of the provider with regards to meeting peoples' needs. One relative told us, "X loves the bath and prefers it in the evening so one of the carers always baths them once a week in the evening which they love". However, comments from other relatives raised concerns with regards to peoples' and relatives' involvement in their care. When asked about peoples' plans of care and their involvement in their review, relatives told us, "No we've not seen one at all and we've not had any reviews" and "I keep asking for one from the manager".

Care plans contained information about peoples' physical and mental health. Some peoples' care plans contained detailed life history, informing staff of peoples' lives before they moved into the home and before their condition had deteriorated, therefore providing staff with useful information that enabled them to build meaningful relationships with people. Assessments for peoples' specific needs, such as mobility and moving and handling had been completed. Care plans were regularly reviewed by nursing and care staff, however, they sometimes lacked detail and did not always advise staff of the changes in peoples' needs in sufficient detail to enable staff to have an understanding of what support the person needed to meet their needs. Care plans had sometimes failed to identify when there had been changes in peoples' needs. For example, several people had lost significant amounts of weight. Records for one person showed that despite the person losing a significant amount of weight, care plan records had not been updated or amended to identify the reason for the person's weight loss or to devise a plan as to how the person could be supported to increase their weight.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. Observations of some staffs' practice showed that they, at times, took time to speak to people and interact with them. The Alzheimer's Society states that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. One person had been showing signs of apparent anxiety and distress throughout the first day of the inspection. Most staff had responded to the person by offering cups of tea or asking the person to sit down. However, one member of staff, when asked to engage with the person by the provider, spent time reminiscing about the person's career and their interest in politics. It was apparent, although the conversation was short-lived, that the person responded well to this and during that time had not called out for assistance or displayed signs of apparent anxiety. This demonstrated that the person responded well to interaction and contact with staff.

On the first and second days of the inspection, observations showed people spending their time sitting in their armchairs, sleeping, walking around the home and appearing to look for things to do. On the third day

of inspection five people were entertained by external musicians who visited the home. There was a lack of person-centred assessments to meet peoples' needs. For example, several people spent their days in their rooms, either in their beds or sitting in arm chairs and as a result were at risk of social isolation. Other people spent their time on their own in the communal lounges or dining rooms. The only stimulation for people came from a television in the main lounge which, on the first day of the inspection, showed an action film. It was not apparent if people had been asked if they would like to watch the film, which was loud and did not create a relaxing atmosphere and observations showed that people did not show an interest in the film. During the afternoon a member of staff, from another of the providers' homes had been asked to visit the home by the provider, to offer some activities to people. We saw the member of staff talking with some people, however, again this was short-lived and other staff had very little interaction with people, other than when providing assistance with peoples' personal care needs or when assisting them to eat and drink. We saw people spending extended periods of time, alone in their rooms, or other areas of the home with minimal interaction from staff, other than to provide personal care or to provide food and drink. We observed that some staff on duty chose to spend their time in rooms, away from people, talking amongst themselves, instead of interacting and engaging with people. Observations showed several people in a communal lounge without staff support. One person was showing signs of apparent anxiety and calling for assistance whilst some staff were in an adjoining room talking amongst themselves.

There was a lack of stimulation and people were at risk of social isolation. Peoples' rooms, although personalised with photographs and memorabilia, did not create a stimulating environment for people to spend their time in. Most people in their rooms did not have anything to occupy their time and they spent their time sitting in their armchairs or in bed sleeping. Care records for one person stated, 'Staff to provide meaningful activities to support good mental and emotional status'. However, observations of the person showed them, on all three days of inspection, in bed with no stimulation or activities to occupy their time.

One person, who was in bed in their room, displayed signs of apparent anxiety, as they were continually crying and calling out for help. The person's room was located on the top floor and they had no means of calling for assistance. Observations showed that as soon as a nearby stairwell door was opened the person began to call for assistance. Records for the person stated, 'X needs to spend time in the communal areas and be encouraged to participate in activities. X sometimes feels isolated due to hearing difficulties. Staff to be aware of the situation and spend time with X'. No staff were observed undertaking regular checks on the person to ensure their wellbeing and an Inspector had to call for staff to assist the person on three occasions. During the afternoon, following feedback to the staff on duty, the person was assisted to get out of bed and go into the communal lounge downstairs. Observations of the person, later in the day, showed that, although there were no activities for them to participate in, they were not anxious and were spending their time watching staff and people.

There was a lack of stimulation and meaningful activities for people, particularly for those that required assistance, were less independent and who spent time in their rooms. When asked about activities and stimulation provided to people and the fact that there had been no provision of activities the provider told us that an activities coordinator had been recruited but were yet to start employment.

There were mixed observations of peoples' dining experience. Some people had their meals in the two dining rooms, with dining tables laid with tablecloths, napkins and cutlery. Other people had their meals in their own rooms. It was not apparent if people had been given any choice with regard to where they ate their meals. People were able to choose what they had to eat and drink and they, and their relatives, told us that people were happy with the choice of food available and that they had access to nutritious food, that was presented well and our observations confirmed this. People, who were able, were encouraged to be independent and specialised equipment and aids were available to support them to achieve this, such as

plate guards and adapted cutlery. However, observations of some people, who had meals placed in front of them, raised questions as to whether they were being enabled to be independent or if there were insufficient staff to assist them with their meals. For example, one person struggled to cut up their food and after a period of time they stopped attempting to cut up their food and consequently stopped eating. We saw people, who had their meals placed in front of them, leaving their food as they were unable to eat independently. Once staff had recognised this they assisted people to eat, however, people were then supported to eat food that had been left to go cold and at times they showed little interest in eating this. It was not apparent if people had been offered an alternative or for their food to be reheated. Further observations raised concerns about the consistency of staffs' practice with regard to assisting people to eat and drink. Most observations demonstrated that staff were patient and calm when offering assistance, they explained their actions, offered people drinks and ensured that people were ready for the next forkful of food. Other observations showed that staff did not take time to interact with people or explain their actions. They did not ensure that people were ready for more food before offering further forkfuls or drinks. Not all people had a positive dining experience.

People did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place. Complaints that had been made had been dealt with appropriately and according to the providers' policy. However, it was unclear what changes had been made and lessons learned in response to the complaints that had been made.

Inadequate

Is the service well-led?

Our findings

There was mixed feedback regarding the leadership and management of the home. Some relatives and staff were complimentary about the registered manager. One relative told us, "I'm very happy with everything and have nothing but praise for them". Another relative told us, "I find them all approachable and I know my relative would say if they weren't happy with anything". A member of staff told us, "The manager is very honest and if I had any problems I would tell him, he is approachable". However, despite these positive comments, we found areas of practice that required improvement.

A majority of feedback demonstrated that people, relatives and staff did not feel that the leadership and management of the home was effective. Comments from relatives included, "The manager seems polite enough but I don't really know him", "Oh I didn't even know there was a new manager" and "The manager is out of his depth". Most staff told us that they were unhappy. Comments included, "It used to be a lovely home, I loved working here, but people are miserable here since the manager came here" and "In the last nine months it has gone downhill and the turnover is very poor because of the management".

Bon Accord is part of the organisation Four Seasons (No9) Limited who have a further three homes across England. They are part of a larger cooperate organisation called Four Seasons. Four Seasons provide nursing care all over England and have several nursing homes within the local area. The management team consisted of a registered manager and senior care assistants. The provider had a philosophy of care that stated 'We are committed to providing the highest possible standards of care. Residents will be treated as individuals and cared for with respect and dignity within a safe, comfortable and homely environment which provides stimulation and encourages independence where appropriate'. We found that this was not implemented in practice.

The registered manager had worked at the home as a registered nurse and had taken on the role of deputy manager before becoming the registered manager in August 2016. However, concerns had been raised to the local authority and CQC with regard to the management of the home. The provider informed us that problems with the management of the home had been identified in December 2016 as concerns had been raised to them by relatives and staff. We were also told that there had been a high turnover of staff, including registered nurses, since the registered manager had been in post. The provider explained that it had become apparent that there had been occurrences within the home and with peoples' care that they had not been made aware of and the registered manager had attempted to deal with situations by themselves. When asked what measures had been put in place to support the registered manager in their new role, the provider told us that support, over and above the amount that was usually provided to registered managers, had been provided. They understood that it was the registered managers first management role and in addition to ensuring that the registered manager undertook the corporate induction they had been allocated a mentor, in the form of another registered manager in another of the providers' homes. However, there was a lack of evidence with regards to the other support that had been offered to the registered manager to ensure that they were fully supported within their new role and that systems and processes, as well as the quality of care people received was meeting peoples' needs.

There was a negative atmosphere and culture and the lack of leadership and management meant that this had failed to be addressed. Existing staff demonstrated a reluctance to accept changes in practice and observations showed staff displaying their unhappiness about the changes that had been proposed to improve practice. For example, after the first day of inspection it was identified that there was a lack of records in relation to peoples' conditions and day-day-health needs. The provider had seconded a registered nurse from another of their services to take on the role as interim deputy manager. They were to have prime responsibility to identify the problems with regard to medicines management and to try to resolve the concerns around medicines as well as updating the care plans for people. The interim deputy manager had taken immediate action and had implemented a recording system for the registered nurses and CHAPS to use. Observations showed some of these members of staff discussing their reluctance to use this and they were overheard saying, "Have you seen what we've got to do now? How are we supposed to find time for this"? and "I don't mind going around and doing all these things, but they're never acted upon". It was apparent that staff were resistant to the changes that had been requested of them and it was evident that the registered manager had faced resistance from staff to accept changes within the organisation and to their practice.

The provider had auditing mechanisms and systems and processes in place to alert the registered manager and provider of when there were concerns regarding the operation and effectiveness of the care provided, to enable them to ensure that the practices of staff were meeting peoples' needs. However, some audits were not effective. For example, food and fluid charts were not consistently completed, this meant that there was insufficient information to identify why people were losing weight. The audits had failed to identify this and there was no evidence that there was any oversight or action taken when people had lost weight. Findings from other audits had not always been used to improve practice and had, at times, not been acted upon sufficiently. There were mechanisms in place to obtain feedback from people, relatives, visitors, staff and visiting professionals. Part of the registered manager's quality monitoring included a facility known as 'Quality of life', this was available for people to provide regular feedback by registering their feedback on an I-pad. The feedback was monitored by the registered manager and regional manager to ensure that any concerns were addressed and action taken in response. In addition to this, resident and relative meetings were held to enable people to share their thoughts and concerns. Quality assurance audits conducted by the registered manager and regional manager provided an oversight and awareness of systems and processes. The amount, frequency and robustness of audits raised concerns with regard to the providers' lack of awareness of the failings of the home. Records showed that although problems had been identified, the registered manager and provider had not taken robust action to ensure that they drove improvement in the quality and safety of the services provided. For example, since December 2016, when the provider explained that they were first aware of the concerns and issues with regard to the management, additional support had been provided in the form of weekly visits by a representative of the provider and a registered manager of another of the providers' services, providing practical support and assistance to the registered manager. However, records of the action plan that was devised at this time showed that there were not robust plans in place to improve the failings that had been identified, such as the on-going, long-standing issues of medicines management. There was ineffective governance and systematic failings that did not ensure the quality of the service and the safety of people. There were concerns that the registered manager had not been provided with sufficient support to enable them to carry out their role. This was echoed within a comment made by a relative, who told us, "The manager is so stretched I blame Four Seasons for not giving them the support they need to do the job properly".

Regular internal audits of the systems were in place for medicines management which were conducted by the registered manager and a representative of the provider. Records of an audit conducted in December 2016 identified that medication was not always in stock and ready for administration on the correct day and that when items had not been received from the pharmacy the reasons for this had not always been

recorded, nor any immediate action taken to resolve the issue. Which meant that some people went without their medicines. An action plan to improve the management of medicines was devised following the internal audit, however, it failed to identify what actions needed to be implemented to ensure that the long-standing issue of people not receiving their medicines was resolved. The action plan stated, 'All missing medications to be reported and meds to be chased ASAP". This did not sufficiently address the severity of the concerns and failed to identify appropriate steps that needed to be taken to resolve the issue. Records showed that numerous health care professionals had met with the provider due to the level of concerns around medicines management and had intermittently provided support to the home to improve its management of medicines for a period of six years. This showed that the provider had failed to improve and sustain improvements in order to ensure people remained safe.

Due to the high turnover of staff the registered manager had recruited new care staff and registered nurses as well as arranging for agency registered nurses to cover the shifts to ensure that there were sufficient staff in line with the providers' dependency tool and optimum staffing levels. However, staff told us that this had caused problems with regard to the lack of experience of some of the new staff. Staff told us that there was a divide between the staff team, that existing staff were unhappy with the influx of new staff, who appeared less experienced than was required. There were concerns that new staff had not received adequate support within their roles to enable them to understand the requirements and responsibilities of their role and ensure that they could effectively meet peoples' needs. There was low staff morale and staff told us that they felt unsupported and unhappy in their work. This attitude and culture was embedded and demonstrated in some staffs' practice. Observations showed them discussing their dissatisfaction and unhappiness in front of people, relatives and CQC. This did not create a homely, happy or warm atmosphere for people.

On the second day of inspection the registered manager resigned with immediate effect. The provider arranged for immediate management cover. Two registered managers from their other services would share the role until a more permanent manager was recruited. The interim deputy manager would also remain at the home to ensure that systems improved. However, there was no management cover over the weekends and some of the management team were working excessive hours, this meant that this was unsustainable and there were no management plans in place for the longer term. For example, on the third day of inspection the interim deputy manager had attended work on their day off so that they could order the medicines, to ensure that people received their medicines on time and ready for the next cycle to begin. Although this showed that the management were committed to making improvements, this demonstrated that the changes and improvements that had been made were reliant on one person and therefore there were not adequate systems and processes in place to prevent the errors that had occurred with regard to medicines management from occurring again.

On the third day of inspection measures were being taken to improve the service. The interim managers and the interim deputy manager had worked hard to change systems such as the systems for ordering medicines. Relatives told us that they felt assured that there was a new management team in place and that they felt that the care and the experience of people would improve. Subsequent to the inspection the provider informed us of the actions that had been taken to address the concerns that were raised as part of the inspection. This included ensuring that one registered nurse was responsible for the ordering and checking of medicines and that a meeting had been arranged with the pharmacy to try to identify and resolve the problems that had occurred. In addition, an expert in dementia care had been providing training and guidance for staff to enable them to support people effectively and human resource 'drop-in' sessions had been arranged for staff to enable them to have a forum to discuss any concerns that they had about the changes that had occurred in an effort to enhance staff morale. However, these were yet to be embedded and sustained in practice.

Records, in relation to peoples' care and treatment, were not always consistently maintained. There were no records that documented peoples' day-to-day conditions. Care staff documented the tasks that they had supported people with, such as assisting them with personal care or the application of topical creams. Registered nurses completed records of contact with external healthcare professionals and when there had been hospital admissions. However, there were no on-going records that documented peoples' daily needs and conditions, this meant that there was no evidence to confirm the practice of staff in relation to the care provided to people to ensure their well-being. For example, records for one person showed that they had sustained an injury and there had been contact with their GP and the person had visited the hospital for an x-ray. However, due to the lack of records there was no information to explain what treatment the person had or how their condition was being monitored or cared for. There were a high level of agency registered nurses and this, as well as the lack of on-going records to document peoples' care and treatment, meant that there was a lack of consistency within the staff team and of peoples' care. As registered nurses were unable to effectively monitor people to ensure that they were being provided with appropriate care.

Records, for people who required frequent repositioning, due to their increased risk of pressure damage were not always completed consistently. There was a lack of guidance for staff to follow in relation to how often a person needed to be repositioned and records showed that there was insufficient information to inform staff of the position and when the person had been supported to reposition. This meant that there was a risk that people were not being repositioned frequently enough and that they were not being supported to change positions to prevent pressure damage. Records, for people who were required to have their food and fluid intake monitored, were not completed sufficiently. For example, records did not provide staff with guidance as to the person's recommended optimum fluid levels and therefore staff were not provided with information to enable them to identify if a person was having insufficient fluids. The recording of food intake was also inconsistent. Records showed that staff had sometimes completed food charts, however, these lacked detail with regard to the amount people had eaten or if their food had been fortified to increase calorie intake.

Staff told us that the lack of records meant that information was often missed and not passed on to other staff. One member of staff told us about a situation whereby a person had been provided with some orthopaedic shoes to enable them to walk independently. Not all care staff had been made aware of this and the person had not been supported to wear the shoes. The person's relative had complained to staff who were then made aware of the change in the persons' needs. Records for another person, who had received end of life care, showed that there was no documentation in place detailing the person's condition or their death. The lack and inconsistency of recording raised concerns regarding the care people received as the provider could not evidence if people had received the necessary care or if staff had forgotten to accurately record their actions.

There were ineffective systems in place to safely store historical records relating to peoples' care. For example, to enable the monitoring of medicines management CQC had requested the MARs for people for the past year. However, staff were unaware where these were stored in their entirety and there was not an effective archive system in place to enable records, which were no longer currently in use, to be stored in such a way that would enable them to be easily retrieved. Failure to archive accurately for ease of retrieval meant that the provider would be unable to effectively audit and identify issues. Staff were unable to find all the records that were requested and therefore the provider was not complying with their legislative responsibilities. The registered manager and provider had not ensured that there were accurate and complete records that were stored securely.

The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided, including the experiences of people who used the service. This

was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
It was not evident, due to the lack detail within records, if the Duty of Candour CQC regulation had been implemented in its entirety and that people and their relatives had been informed of the failings in peoples' care, such as the on-going, long-standing errors with regard to their access to medicines. (The intention of this regulation is to ensure that providers' are open and transparent with people who use services and other 'relevant persons'). This is an area of practice in need of improvement.