Crown Care V Limited

Royal Hampton

Inspection report

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26 September 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19, 23 and 26 September 2016. The visits on the 19 and 23 September were unannounced. This meant that the provider and staff did not know we would be visiting. We carried out a further announced visit to the home on 26 September 2016 to complete the inspection.

This home opened in January 2016 and this was our first inspection of the service. We brought forward our planned comprehensive inspection because we received information of concern related to staffing levels, safe care and treatment and the governance of the service.

Royal Hampton is a 73-bed home providing residential, nursing and dementia care. The facility includes a library with internet café, quiet lounge, social room and Shakespearean restaurant. There is also a treatment room where beauticians and therapists offer spa treatments, manicures, pedicures, massages and facials. Each of the single bedrooms has en-suite shower rooms and there are a number of suites with private lounges and kitchens. There were 17 people living at the home at the time of the inspection.

There was a manager in place during our inspection. They were not yet registered with the Care Quality Commission as a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Following our inspection, the manager's employment with the provider ended.

We found that systems and processes were not fully in place or operated effectively, to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager carried out a number of audits and checks on aspects of the service. We noted however, that these did not always highlight the concerns which we found. We identified shortfalls with record keeping and confidentiality. There were gaps in the recording of some people's care and treatment. In addition, care plans and risk assessments for one person had not been completed. We found confidential information regarding people's care and treatment stored on the table in the open nurses' station on the first floor.

People, relatives and staff told us there were insufficient staff deployed to meet people's needs. There was a high use of agency staff. People and relatives raised concerns about continuity of care We identified issues with staff deployment and their skill mix and found there were insufficient suitably qualified, competent, skilled and experienced staff to meet people's needs.

Most people told us they felt safe living at the home. However, some relatives informed us that due to the high use of agency staff; they considered there were times when their family members were not always as safe as they could be. One person had sustained an injury. This incident and subsequent injury had not been referred to Northumberland safeguarding adults team in line with protocols, or the Commission. This meant the person was not fully protected from the risk of abuse and improper treatment because the incident had

not been referred to the correct authorities to check whether the appropriate action had been taken to safeguard the individual.

The manager explained that staff induction at the home had not been as thorough as they would have liked because of staffing issues. They told us that they were aware there were some gaps in training provision and explained that further training was planned. Documented induction and competency checks for agency staff were not always available. This meant it was not clear what clinical skills certain agency staff had to ensure that people's needs were met by suitably qualified, competent, skilled and experienced staff. Checks were carried out to ensure that applicants were suitable to work with vulnerable people. This included obtaining at least two written references and a Disclosure and Barring Service check [DBS].

There were gaps and omissions relating to medicines management, including the recording of controlled drugs. We found that a robust system for the receipt of medicines coming into the home was not fully in place and medicines had not always been administered as prescribed.

We checked the condition and suitability of the premises. The furnishings were luxurious and all areas of the building were well maintained.

The provider used a computerised care management system which was used to plan and review people's care and support. This system flagged up when reviews were due for care plans and assessments. We found however, that people's care records were not always accurate or up to date.

On the first day of our inspection, Deprivation of Liberty Safeguards [DoLS] applications had not been submitted to the local authority for authorisation where it was indicated that people's plan of care amounted to a deprivation of liberty. On the third day of our inspection, the manager told us that two DoLS applications had been submitted.

People were complimentary about meals at the service. We saw that staff supported people with their nutritional needs.

Most of the interactions we saw between people and staff were positive. We found however, that staff sometimes overstepped professional boundaries and discussed work matters with people and relatives.

People told us that their social needs were met. There was an activities coordinator in place. On the second day of our inspection however, the activities coordinator was diverted from activities provision to help with care duties which the provider stated was due to an emergency situation at the home.

Two people had recently been admitted to the home. We noted that a preadmission assessment had not been carried out prior to them coming into the home. The provider informed us that preadmission assessments had always been carried out prior to people moving to the home except in relation to these two individuals, one of whom had been admitted as an emergency admission. They told us that in an emergency situation, a formal preadmission assessment may be completed on admission to the home.

There was a complaints procedure in place. People and relatives told us that they knew about the complaints process.

Staff told us that morale was very low which most staff informed us was due to the management of the service. We looked at staff rotas and noted that seven of the 32 staff had been off sick at various intervals over the two weeks prior to our inspection.

We referred all of our concerns about the service to the local authority and Northumberland Clinical Commissioning Group.

We found six breaches of the Health and Social Care Act 2008. These related to safe care and treatment, person-centred care, need for consent, safeguarding people from abuse and improper treatment, staffing and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

Most people told us that they felt safe. However, some relatives told us that due to the high numbers of agency staff used, people were not as safe as they could be. One person had sustained an injury. This had not been reported to the local authority's safeguarding adults team or the Commission.

Risk assessments had not always been carried out to assess risks people faced in their daily lives.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

There were gaps in the provision of training. Plans were in place to source additional training.

The manager explained that staff induction at the home had not been as thorough as they would have liked because of staffing issues. Documented induction and competency checks for agency staff were not always available.

People were complimentary about meals at the service.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that permanent staff were caring.

Most of the interactions we saw were positive. We found however, that staff sometimes overstepped professional boundaries and discussed work matters with people and relatives.

Information about people's preferences and choices had not always been completed in their computerised care records.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We noted that preadmission assessments were not always carried out prior to people moving into the home.

A computerised care management system was in place to assess and review people's care. However, care plans and assessments were not always accurate or up to date.

People and relatives informed us that people's social needs were met.

There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well led.

An effective system was not in place to monitor the quality and safety of the service. We identified serious shortfalls in various aspects of the service.

Staff told us that morale was very low which most staff informed us was due to the management of the service.

Royal Hampton

Detailed findings

Background to this inspection

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

The inspection was unannounced and carried out by two inspectors on 19 and 23 September 2016 and one inspector on the 26 September 2016.

We spoke with 10 people who lived at the home. We also spoke with four relatives. We spoke with the nominated individual, the regional manager, manager, business manager, two senior care workers, two care workers, the laundry assistant, housekeeper, a member of the domestic team, the activities coordinator, and maintenance person. We also conferred with the local authority safeguarding and contracts and commissioning teams. We also spoke with a health care professional.

Prior to our inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern.

We did not request a provider information return (PIR) prior to the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection, we received information of concern regarding staffing levels at the service. In addition, the manager had submitted a notification to inform us that there had been no nurse on one particular night shift. This meant there had been no nurse to supervise the care and treatment of people with nursing needs.

Following our inspection, the provider wrote to us and stated that additional safety measures had been put into place when there had been no night nurse on duty. There had been an on call nurse from one of the provider's nursing homes and all the care workers on duty were regular staff who were very familiar with the service.

People, relatives and staff told us that more staff were required. Comments from people included, "More staff would make it better. I have to wait for everything" and "It's been a bit chaotic recently…Sometimes the staff don't turn up." One relative told us, "The permanent members of staff have been very good, there's just not enough of them."

The manager told us that there was usually one nurse and either three or four care workers on duty. We examined staff rotas and noted that on one day there had only been one nurse and two care workers on duty. We also saw that a high proportion of agency staff were used. On the Saturday prior to our inspection there had been a nurse who had just started working at the home, two agency staff and a nurse from one of the providers other care homes on duty through the day. Following the inspection the provider wrote to us and stated that the deputy manager had also been at the home although this was not confirmed by the staff rotas we viewed. The manager told us and staff rotas confirmed that there had been increased staff sickness. There was a lack of bank staff to cover shifts which permanent staff were unable to work. One member of staff told us, "We don't have any bank staff which would help."

On the first day of our inspection, one person was assisted up and had their breakfast at 11.45am. We spoke with the staff member about this issue. They told us, "There was only [name of staff member] and I, that is why [name of person] was late getting up." Following our inspection, the provider wrote to us and stated that the staffing numbers had been appropriate and the staff member should have requested additional support and this would have been available."

We checked people's computerised care records and found that records for people who lived on the nursing floor were not always accurate or up to date. We spoke with a staff member who said, "We don't have time… You are writing the basics."

This deployment and staff skill mix placed people and staff at risk of harm because there were insufficient suitably qualified, competent, skilled and experienced staff on duty to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Staffing.

Following our inspection, the provider sent us staff rotas on a weekly basis which demonstrated that staffing levels were maintained and which the provider stated met people's assessed needs.

Most people told us that they felt safe living at the home. However, some relatives informed us that due to the high use of agency staff; they considered that there were times when their family members were not always as safe as they could be. Following the inspection, the provider wrote to us and stated, "The use of agency care assistants provided was an extra precautionary measure put in place to ensure that safe staffing levels could be maintained in the event of any care staff being absent/sick at the last minute and this measure was to give additional support to further bolster the day staff care team."

We spoke with one person who had sustained an injury. We spoke with a health care professional regarding the injury and subsequent treatment. They told us that the treatment provided was "not acceptable." This incident and subsequent injury had not been referred to the safeguarding adults team or the Commission. This meant the person was not fully protected from the risk of abuse and improper treatment because the incident had not been referred to the correct authorities to check whether the appropriate action had been taken to safeguard the individual. We are dealing with this incident outside of the inspection process.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safeguarding people from abuse and improper treatment.

A preadmission assessment had not been carried out for two people prior to their admission to ensure the service could meet their needs. We spoke with a member of nursing staff who told us, "I haven't been shown how to do a pre-assessment." We spoke with the regional manager who said, "There is a misunderstanding that if people come in as an emergency admission, then they don't need a preadmission assessment, but they still do." This omission and lack of timely preadmission assessment meant that staff had not ensured that people's needs could be met by the service prior to their admission and they had not done all that was reasonably practicable to mitigate any risks.

Following the inspection, the provider wrote to us and stated that preadmission assessments had always been carried out prior to people moving to the home except in relation to these two individuals. One of whom had been admitted as an emergency admission. They told us that in an emergency situation, a formal preadmission assessment may be completed on admission to the home.

We read one person's daily records and noted that staff had highlighted a number of risks relating to their health condition. No risk assessments or care plans had been completed to instruct staff what action they should take to reduce these risks and ensure the person's safety and wellbeing. We examined another person's computerised care records and saw that there was no care plan in place. This meant that information to ensure staff provided consistent treatment to optimise healing was not in place.

We checked the management of medicines. People did not raise any concerns about medicines management. One person said, "I keep a note of my medicines. I get paracetamol – eight a day, so it can be slightly later [when I get them], but not any sooner than four hours. I get a special tablet once a week."

One person self-administered one of their medicines. We noted however, that information about how this should be managed was not recorded in their care records. This meant that it was not clear how this person's self- administration was being monitored and managed to ensure they received their medicines safely and as prescribed.

We checked the management of controlled drugs. These are medicines which are liable to misuse and

require stricter controls to ensure their safe storage and administration. We read the controlled drugs register and noted that staff had recorded that several controlled drugs had been returned to the pharmacy in August 2016. We noted however, that these were still in stock and had not in fact been returned. This meant that records relating to controlled drugs were inaccurate and therefore controls to prevent controlled drugs being misused, obtained illegally or causing harm were not fully in place.

We found that several medicines belonging to one person had been out of stock for two days. This meant that sufficient quantities of appropriate medicines were not always maintained. There were some gaps in the recording of medicines administration. Daily stock balance checks indicated that one person had not received one of their medicines for two days. Staff were unable to provide us with a reason for this non-administration.

There had been several recent medicines errors. One person was given the wrong medicine dosage because staff had not identified that the incorrect dose had been received from the pharmacy. Another person had not received one of their medicines for four days because the medicine had not been recorded on the MAR. This meant that a robust system for the receipt of medicines coming into the home was not fully in place and medicines had not always been administered as prescribed.
Following our inspection, the provider wrote to us and stated, "The errors were identified as part of the company's own medication quality audit processes…in all cases, immediate actions had been taken, including submitting relevant statutory reporting and safeguarding and CQC notifications, follow up, reflective practice and learning the lessons."

Personal evacuation plans had been completed. We noted however, that one person did not have a PEEP in place. In addition, the evacuation folder which contained information to be used in the event of an emergency, located on the ground floor, was not up to date. This meant that there was a risk that information to support people to evacuate the building safely in an emergency was not always available.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safe care and treatment.

We checked the condition and suitability of the premises. The furnishings were luxurious and all areas of the building were clean and well maintained. People told us that they were happy with the facilities and their accommodation. Comments included, "It's pretty good – it's comfortable," "There's a nice set up here because I've been able to bring quite a lot of my own things. It makes a big difference if you have your own things around you" and "The surroundings are beautiful."

Staff had access to personal protective equipment. One member of staff informed us however, that the manager had told them they had to limit their use of gloves to cleaning toilets. We spoke with the manager about this feedback; they informed us that they had told the staff member they could wear gloves when dealing with all chemicals, however, not to wear them all the time for tasks such as hoovering. The infection control team had been asked to visit by the local authority to advise them on this issue.

We examined staff recruitment. Checks were carried out to ensure that applicants were suitable to work with vulnerable people. This included obtaining two and in some cases three written references including one reference from the applicant's previous employer and a Disclosure and Barring Service check [DBS] to help ensure that staff were suitable to work with vulnerable people. We were satisfied that procedures followed to recruit staff were thorough.

Requires Improvement

Is the service effective?

Our findings

Most people and all relatives informed us that permanent staff at the home knew what they were doing. They told us however, that there was a high proportion of agency staff who did not know people's needs. One relative said, "There have been a lot of agency staff and it is a worry for continuity and how [agency] staff know how to meet [relative's] complex medical condition…I wonder whether they have the expertise."

The manager told us that there was an induction process in place. They said however, that due to the current staffing issues; the induction period was not as thorough as they would have liked. We spoke with one staff member who told us that they had not felt supported. Another member of staff informed us that they had not received an induction at the home. They said, "I have had no training or induction yet." This meant that there was a risk that staff had not received an appropriate induction to ensure that they had achieved acceptable levels of competence in the duties they were employed to perform.

The manager said that agency staff received an induction and competency assessment when they first worked at the home. We noticed however, that most of the documented induction and competency checks for agency staff were missing. We spoke with the manager about this issue. They told us, "I'll have to chase this up." Following our inspection the provider wrote us and stated that most of the induction and competency checks had been completed.

The provider used two agencies to provide staff. Both agencies sent the home an overview of each member of agency staff which included information about recruitment checks and mandatory training. We saw however, that one of the agencies did not send details of the skills of agency nurses such as being skilled with wound care or catheterisation. This omission meant that it was not clear what clinical skills certain agency staff had, to ensure that people's needs were met by suitably qualified, competent, skilled and experienced staff.

The manager provided us with information about training. We viewed the training records of two of the domestic staff. They had started work at the home in May 2016. We noted that they had just completed fire safety training. No further training in areas such as the Control of Substances Hazardous to Health [COSHH] or infection control had been completed. This was confirmed by the staff themselves.

Some staff informed us that they had completed training in their previous jobs. We noted however, that training certificates to evidence this training were not included in their files to demonstrate that they had completed this training and were competent to carry out the duties they were employed to carry out.

We read people's computerised care records on the nursing floor and noted that these were not always accurate or up to date. In addition, one person had no assessments or care plans in place. We spoke with one of the nurses who explained that she had worked at the home for three weeks and had not completed training with regards to how to use the computerised care management system until the second day of our inspection. This meant that people's care and treatment had not always been assessed, reviewed or updated because not all staff had completed training in this area.

We read a recent training audit. This stated, "There are gaps on the training matrix that need to be addressed via e-learning or by face to face training." Not all staff had carried out training in MCA. One member of staff asked us for advice in this area and felt that further training was required. The manager told us they were aware there were some gaps in training provision, however, further training was planned in dementia care, health and safety and the computerised care management system. Following our inspection, the provider wrote to us and stated that MCA training had already been organised prior to our inspection

Most staff told us that they did not feel supported by the manager. Comments included, "We don't feel looked after or supported" and "Sometimes they come across as really unapproachable." We discussed this feedback with the manager and regional manager. They told us that staff meetings were being held and their human resources were currently at the home speaking with staff about their concerns.

We checked staff supervision records. The manager told us that they had identified gaps in staff supervision which were being addressed. We noted that one staff member had started work in June 2016 and had not yet received supervision.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Staffing.

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.

On the first day of our inspection, no DoLS applications had been submitted to the local authority, despite staff telling us that several people's plans of care amounted to a deprivation of liberty. We heard one person with a dementia related condition requesting to go home. On the third day of our inspection, the manager told us that they had sent two DoLS applications to the local authority for authorisation.

We read one person's mental capacity risk assessment which had been completed in May 2016. This stated, "Although we feel DoLS authorisation is needed for [name of person] this has yet to be applied for." Their "consent assessment" which had been completed in May 2016 also stated, "There is no record of [name of person] providing any form of consent for on-going care at this time, this is an urgent requirement." The manager informed us that a DoLS application had not been completed for this person. This meant there was a risk that this individual was being deprived of their liberty without lawful authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safeguarding service users from abuse and improper treatment.

We noted that one person's mental health assessment contained conflicting and confusing information. Staff had recorded that they did not lack mental capacity; however, their assessment also stated that a DoLS application was required. This meant that information regarding people's mental capacity was not always clear or accurate to ensure that the principles of the MCA could be followed. Staff told us and records confirmed that they had moved this individual with a dementia related condition from the nursing unit on the first floor to the ground floor. There was no evidence that a mental capacity assessment had been carried out to assess this specific decision.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Need for Consent.

We checked how people's dietary needs were met. People and relatives informed us that they were happy with meals at the service. Comments included, "The food is excellent – they use expensive food," "The food is very good here. I don't start eating until lunch time. I just have something small. I have facilities to make snacks. I can't cook but I have a fridge" and "There is a good choice of meals, we choose the day before and we get what we ordered. The food is very good. I press the buzzer and get cups of tea any time you want it."

Staff told us and our own observations confirmed that relatives were welcome at mealtimes. One person's husband joined her at lunchtime on the first day of our inspection. He told us, "The food is lovely." This meant that staff recognised the importance of socialising at mealtimes.

We spent time observing the lunch time periods on both days of our inspection. We saw that staff supported people with their meals. They helped those people who required assistance to cut up their food and provided drinks throughout the meal. We heard comments such as "Can you manage?" "Do you want your soup now?" and "Ooohh it looks lush [very nice] doesn't it?" The person agreed. A staff member observed that one person was not enjoying their salad. They asked him whether he would like an alternative. The person thanked the staff member and said that he would just continue with his salad.

We checked whether people had access to health care services. People and relatives told us that staff contacted relevant healthcare professionals when required to meet people's health care needs. We read that people saw their GPs, district nurses and attended hospital appointments as and when required.

People and their relatives told us that the design and layout of the building met their needs. Each of the single bedrooms had en-suite shower rooms. There were a number of suites with private lounges and kitchens. There was a library with internet café, quiet lounge, social room and Shakespearean restaurant. There was also a treatment room where beauticians and therapists could offer spa treatments, manicures, pedicures, massages and facials. The unit for people with a dementia related condition was situated on the second floor. This was not yet open. We saw that the unit was designed and decorated to meet the needs of people with a dementia related condition.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were caring. Comments included, "The staff are dedicated," "Everyone is very nice," "They are kind to you," "We are well looked after," "Oh yes, the staff are caring" and "The staff are very good. I'm reasonably self-sufficient, but they are very considerate." A relative said, "They have been so caring. Nothing has been too much trouble"

We observed how staff interacted with people. Most of the interactions we saw were positive. One member of staff said to a person, "Can I come and sit with you and have my coffee?" Another staff member said to an individual, "You have the most lovely smile." A 'front of house' member of staff was employed to welcome everyone who visited the home. We saw she spent time with people at lunch time to ensure that the mealtime was a social experience and people's needs were met.

We found however, that not all interactions were positive. We heard one staff member informing a person who was already anxious about the "dreadful morning" the person and staff member had had because of the issue with "staffing levels." This interaction did not lessen the person's anxiety or reassure them. We informed the manager of our observations.

Permanent staff were knowledgeable about people's likes and dislikes and could describe these needs to us. One staff member said, "[Name of person] loves handbags and she loves shopping. [Name of person] likes gardening and [name of person] loves golf. [Name of person] loves socialising and is very family oriented. [Name of person] always asks me about my animals. I know that something is wrong if he doesn't ask me about my animals." This meant that staff were aware of people's likes and dislikes so that person centred care could be provided. We noted however, that information about people's preferences and choices had not always been completed in their computerised care records.

People and relatives told us that staff promoted people's privacy and dignity. A staff member told us, "We always knock on doors and ensure personal care is carried out in private." We found however, that staff had sometimes overstepped professional boundaries and discussed confidential incidents at the home with certain relatives. In addition, we found certain confidential information relating to people's care and treatment was stored on the desk in the open plan nurses station. We informed the manager of our findings. Following the inspection, the provider wrote to us and stated, "The importance of confidentiality has since been reinforced through relevant specific topic supervisions."

We observed that staff knocked on people's doors before they entered and spoke with people respectfully. One person indicated that they needed to use the toilet and staff discreetly supported them to the toilet.

People and relatives told us that staff promoted people's independence. One person told us, "I have made more progress here" and "It's excellent for rehabilitation. I can now walk with a frame." We spoke with their relative who said, "They have done a fantastic job." There were a number of suites with private lounges and kitchens which the provider stated on their website helped promote people's independence.

Our discussions with staff revealed there were no people in receipt of care from the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The manager informed us that no one at the home was currently using an advocate. An advocate represents and works with a person who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

Most people informed us that the permanent staff were responsive to their needs but there were high levels of agency staff used. One person said, "There's no continuity, that's what we need." The health and social care professional told us, "There is no continuity…. They [agency staff] don't know the residents."

Two people had recently been admitted to the home. We noted that a preadmission assessment had not been carried out prior to them coming into the home. One person was admitted to the home on the second day of our inspection. Two staff informed us that they were unaware that this person was being admitted to the home until they "arrived with their suitcase." A member of staff said, "A preadmission assessment has not been carried out, so the agency nurse is doing it now." This meant that an effective system to ensure that people's needs could be met at the service in advance of their arrival was not fully in place. Following the inspection, the provider wrote to us and stated that preadmission assessments had always been carried out prior to people moving to the home except in relation to these two individuals. One of whom had been admitted as an emergency admission. They told us that in an emergency situation, a formal preadmission assessment may be completed on admission to the home.

We found that it was not always clear whether people required nursing or personal care. Staff told us that they considered that one person required nursing care. Following our inspection, the provider told us that they could provide nursing or residential care on both floors so the "right care and treatment was always provided."

The provider used a computerised care management system to plan and review people's care and support. This system flagged up when reviews were due for care plans and assessments.

People's computerised care records did not always reflect their needs. We read one person's care records which stated that they used a stand aid hoist for all moving and handling transfers. We spoke with staff who explained that the stand aid hoist was no longer used. We read that another person had a catheter. There was no information to state what size of catheter was required. In addition, we noted that information about people's preferences and choices had not always been completed in their computerised care records.

These omissions meant that there was a risk people may receive incorrect treatment since their care records were not always up to date. We spoke with a health professional who said, "They [care plans] need to be clear and up to date especially with agency staff going in."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Person-centred care.

Most people told us that their social needs were met. One person commented, "Oh yes, there's enough going on." A relative said, "The activities are improving. They are trying to organise more trips out." There was an activities coordinator employed to help meet people's social needs. We spoke with the activities coordinator who told us, "I organised Salsa dancing the other day and they enjoyed it so much we did it

again." People told us that a movie night was planned. One person went to see the cinema room on the top floor and told us they were very impressed with the surround sound and were looking forward to the film. They told us, "We have popcorn - we have a choice of salted or sweet. You should come and watch it with us." We read that "Family and friends" events were planned. We saw that a Halloween party was planned.

On the second day of our inspection the activities coordinator was diverted from activities to support with care duties. Following our inspection, the provider told us that the activities coordinator had been diverted due to an emergency situation and social support was provided by all the staff at the home, not just the activities coordinator.

There was a complaints procedure in place. People and relatives told us that they knew how to make a complaint. We noted that one relative had raised a complaint about staffing levels. The manager had written a short response to the relative informing them that staffing levels were within recommended levels advised by CQC. CQC however, do not provide specific advice and guidance on staffing levels. Another relative with whom we spoke informed us that they were going to make a formal complaint to the manager about their concerns.

Inadequate

Is the service well-led?

Our findings

The home had opened in January 2016 for people who required accommodation and personal care. The nursing unit opened in July 2016. There had been two managers at the home since it opened, one of whom had been registered with CQC. In addition an assistant manager had overseen the management of the service from June to July 2016. The manager who was present during the inspection had been in post for a month and was not yet registered with CQC. Following our inspection, the manager's employment at the service ended and the provider re-deployed the assistant manager who was already known to people, relatives and staff back to the home with support from the regional manager.

We spoke with people, relatives and staff about the leadership at the service. Most of the staff and several relatives raised concerns about the manager. Most of the staff told us that they found the manager unapproachable and sometimes abrupt in their manner. Comments from relatives included, "I don't have the same connection with [name of manager] as I do with [name of deputy manager]. They are locked away in the office and not as engaged" and "I'm sure [name of manager] is a lovely person, but things aren't happening. I find myself repeating things at each of the meetings we have had…I get no feedback about what has been done."

Staff told us that morale was low which most staff informed us was due to the management of the service. One staff member said, "Morale is awful, we are only in here for the residents." Human resources were at the home on the second day of our inspection and were speaking to staff about their concerns. We looked at staff rotas and noted that seven of the 32 staff had been off sick at various intervals over the two weeks prior to our inspection.

We observed the manager spent most of their day in the office on all three days of our inspection. This meant she was not present on the floor supervising and directing staff to ensure the safety and wellbeing of people who lived there.

We found that systems and processes were not fully in place or operated effectively, to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider wrote to us and stated that they had already identified the issues at the service and had organised for an external human resources advisor to investigate the concerns. They also arranged for the assistant manager to provide management cover following the departure of the home's manager.

The manager carried out a number of audits and checks on aspects of the service. We noted however, that these did not always highlight the concerns which we found. Accidents and incidents were analysed, however not all accidents were recorded. We identified shortfalls with record keeping and confidentiality. There were gaps in the recording of some people's care and treatment. A care plan had not been written to instruct staff about one person's treatment regime following an injury. There was confusing and conflicting information in one person's computerised records we viewed. In addition, we noted that another person's name was mentioned in one person's care plan. There had been no care plans or risk assessments completed for one person who had been at the home for a week. In addition, there were gaps and omissions

relating to medicines management, including the recording of controlled drugs.

We found confidential information regarding people's care and treatment stored on the table in the open nurses' station on the first floor. The nurse acknowledged that this information should have been locked away. Staff informed us that sometimes it was difficult to conduct confidential telephone conversations since the phone was located in the open office area.

These gaps and omissions meant accurate, complete and contemporaneous records were not always maintained safely or securely to ensure people's health, safety and wellbeing.

We also identified shortfalls in the maintenance of records relating to the management of staff. The provider informed us that an accident record relating to an injury sustained by a member of staff was inaccurate. In addition, there was no documented supervision to record the actions which were taken following the injury. Documented induction and competency checks for agency staff were not always available and we were not able to evidence training which staff had completed in their previous jobs. We examined staff rotas and noted on the Saturday prior to our inspection there had been a nurse who had just started working at the home, two agency staff and a nurse from one of the providers other care homes on duty through the day. Following our inspection, the provider informed us that the deputy manager had also been at the home which was not reflected on the rota.

We found that staff on occasions had overstepped professional boundaries with regards to the information they shared with relatives. Relatives were able to inform us of events and incidents which had occurred at the home.

Staff told us that handover procedures could be improved. One staff member said, "The handovers could be much better instead of saying 'No changes.'" They also said that an effective handover system for agency staff was not in place. They showed us their handwritten notes which they used to give agency staff a handover. This meant there was a risk that important information about people's care and treatment may be missed. There was a lack of evidence to demonstrate that staff were provided with up to date and accurate information which enabled them to meet people's needs consistently, safely and effectively.

We spoke with the manager about policies and procedures. She told us "(Name of regional manager) is currently doing them and is going to roll them all out." One staff member told us, "I haven't been through any policies or procedures yet. Following our inspection, the provider wrote to us and stated that there had been relevant and current policies and procedures in place at the time of the inspection, which were readily available. They stated that they were in the process of updating the policies and procedures.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Following the inspection, the provider wrote to us and stated, "Great strides have been made to ensure that high standards are once again being maintained and effectively evidenced."

The regional manager told us and staff confirmed that staff meetings were being held to discuss their concerns. Meetings for people and relatives were also carried out.to obtain their feedback and involve them in the running of the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of people was not always appropriate or met their needs. Assessments of the needs and preferences for care and treatment of people had not always been carried out. Regulation 9 (1)(a)(b)(3)(a)(b).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	There was a lack of evidence to demonstrate that care and treatment was always provided with the consent of the relevant person. Regulation 11 (1).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided safely. Risks to the health and safety of people had not always been assessed and action had not always been taken to mitigate any such risks. Medicines were not always managed safely. Regulation 12 (1)(2)(a)(b)(f)(g).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Treatment of disease, disorder or injury	The correct action had not been taken following one allegation of abuse to ensure that the person was protected from abuse and improper treatment. Deprivation of Liberty Safeguards [DoLS] applications had not all been submitted for authorisation where it was indicated that people's plans of care amounted to a deprivation of liberty. Regulation 13 (1)(2)(3)(5).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to monitor the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of people and others. Records relating to people, staff and the management of the service were not always accurate, complete or securely maintained. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(f).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Staff did not always receive appropriate support, training and supervision as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1)(2)(a).

The enforcement action we took:

We imposed conditions on the provider's registration.