Care Worldwide (Nottingham) Limited

Beechdale Manor Care Home

Inspection report

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08 December 2016
19 December 2016
20 December 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 30 November, 8 December, 19 December and 20 December 2016

Beechdale Manor provides accommodation, nursing and personal care for up to 65 older people, some of whom were living with dementia. There were 44 people living at the service at the time of our inspection.

At the time of our inspection there was no registered manager in post. The registered manager had stopped working as the manager in May 2016 and had since left the service. Interim management arrangements had been in place until the new manager had commenced working at the service approximately a month before our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection on 16 and 17 August 2016, we asked the provider to take action in relation to a number of breaches of regulations. Following the inspection the provider sent us an action plan to inform us of planned improvements. During this inspection we found some improvements had been made in line with the action plan, however we identified further improvements were required to ensure people were safe and received care which was specific to their needs and preferences. We also identified further breaches of regulation.

People were not always safely supported when being assisted by staff to mobilise around the service. Potential safety hazards such as unsafe access to medicines and inaccurate information about people who lived at the service had not been identified or responded to. Safety checks to equipment were being carried out on a regular basis.

People were protected from the risk of abuse as management and staff understood their role in keeping people safe from harm.

Staffing levels identified by the provider were being maintained however people told us that their needs were not always responded to in a timely way.

Staff had not always been recruited following safe recruitment practices.

Improvements were required to the administration of medicines to ensure this was safe and that people received their medicines as prescribed.

People were supported by staff who had received training and were supported by the management team to ensure they could perform their roles and responsibilities effectively.

People were encouraged to make choices and decisions however; people's rights were not fully protected under the Mental Capacity Act 2005. The registered manager had applied for authorisations to deprive people of their liberty if required. However, further advice or authorisation had not been sought when the restrictions on people had changed.

People told us they found the food satisfactory and that people's dietary requirements were known and catered for. People received support to maintain their hydration, nutrition and healthcare although documentation required improvement.

Staff were kind and people were treated with dignity and respect. People were given information and choices and supported to maintain their independence.

There was some evidence to show that people were involved in decisions about their care and advocacy information was available to people.

People did not always receive care that was responsive to their needs and preferences. Staff were not always provided with sufficient guidance or in some instances the guidance provided was not being followed. This resulted in negative outcomes for some people.

People and their relatives felt able to approach the management team with any concerns and we saw that action had been taken to address concerns which had been raised.

Systems in place to monitor and improve the quality of the service provided were not effective in responding to issues in a timely way. Information and feedback was not used effectively to drive continuous improvements at the service.

People told us that the management of the home were visible and approachable and staff felt supported and motivated. People and their relatives were given opportunities to be involved in the development of the service.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The overall rating for this service is 'Requires Improvement'. However, that service has been rated as 'Inadequate' in one key question over two consecutive comprehensive inspections therefore will remain in special measures.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. For adult social care services the maximum time for being in special measures will usually be no more than 12 months.

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.

People were not always safely supported when being assisted by staff to mobilise around the service.

Potential safety hazards such as unsafe access to medicines and inaccurate information about people who lived at the service had not been identified or responded to. Safety checks to equipment were being carried out on a regular basis.

People were protected from the risk of abuse as management and staff understood their role in keeping people safe from harm.

Staffing levels identified by the provider were being maintained however people told us that their needs were not always responded to in a timely way. Staff had not always been recruited following safe recruitment practices.

Improvements were required to the administration of medicines to ensure this was safe and that people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had received training and felt supported by the management team. However, we were not always assured of staff competency following training.

People were encouraged to make choices and decisions however; people's rights were not fully protected under the Mental Capacity Act 2005.

The registered manager had applied for authorisations to deprive people of their liberty if required. However, further advice or authorisation had not been sought when the restrictions on people had changed.

People told us they found the food satisfactory and that people's

dietary requirements were known and catered for. People received support to maintain their hydration, nutrition and healthcare although documentation required improvement.

Is the service caring?

Good

The service was caring.

Staff were kind and people were treated with dignity and respect. People were given information and choices and supported to maintain their independence.

People were involved in decisions about their care and advocacy information was available to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was responsive to their needs and preferences.

People were at risk of receiving inconsistent support as some care plans did not contain sufficient guidance for staff on how to meet people's individual needs. In some cases guidance in care plans was not being followed by staff.

People and their relatives felt able to approach the management team with any concerns and we saw that action had been taken to address concerns which had been raised.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality of the service provided were not effective in responding to issues in a timely way.

Information and feedback was not used effectively to drive continuous improvements at the service.

People told us that the management of the home were visible and approachable and staff felt supported and motivated. People and their relatives were given opportunities to be involved in the development of the service.

Beechdale Manor Care Home

Detailed findings

Background to this inspection

This inspection of Beechdale Manor Care Home commenced on 30 November 2016. The purpose of the inspection was twofold and was prompted in part by notification of an incident following which a service user died. This incident is currently being considered separately and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

We previously carried out an unannounced comprehensive inspection of this service on 16 and 17 August 2016. Breaches of legal requirements were found and we took enforcement action. We undertook this comprehensive inspection to also check the provider was now meeting legal requirements. We checked whether the provider is meeting the 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.

We inspected the home on 30 November, 8 December, 19 December and 20 December 2016. This was an unannounced inspection. The inspection team consisted of four inspectors, a specialist advisor in moving and handling and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we checked the information that we held about the service such as information we had received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our visits we spoke with 13 people who lived at the service and five relatives. We also spoke with a senior care worker, six care workers, a nurse, the activities co-ordinator, the maintenance person, head housekeeper, the manager and a regional manager. We looked at the care records of 13 people who lived at the service, the recruitment records of four members of staff, as well as a range of records relating to the running of the home. We observed care and support in communal areas of the home. We also spoke with

four visiting healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 16 and 17 August 2016, we asked the provider to take action to ensure that people were cared for in a way that protected them from risk of harm. This was because risks to people were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, although improvements had been made in relation to supervision of people and safety checks of premises and equipment, we found that people were still at risk of harm.

Prior to this inspection we received information of concern as to how people were kept safe from the risk of falling and supported with their mobility. During this inspection we found that improvements were required to keep people safe.

Some people told us they were not always confident with the assistance provided by staff when supporting them to use equipment which enabled them to move position. One person told us, "The night staff are not as good with the hoist as day staff. They fumble more. I've only had the occasional bump." Other people we spoke with told us that they felt that staff supported them with their mobility safely and would remind them to use their walking aid to reduce the risk of falls.

We observed that staff did not always follow safe practice when supporting people with their mobility. For example, we saw that a person was being supported to change their position with a hoist and sling. The staff members recognised that the person was slipping through the sling and stopped trying to hoist the person however did not check whether they were using the right sling and whether this had been fitted correctly.

We looked at the persons care records which did not identify the type of sling the person required for different transfers or which loops to use when attaching to the hoist. Slings have different length loops for attachment to the hoist to increase the person's comfort and to alter positioning. The person should be assessed for the type of sling and the correct loops so that they are not at risk of harm. We were not provided with evidence of this assessment having taken place.

We told the regional manager about what we had observed. They confirmed that the person had two types of sling available and following our feedback, they ensured that both types of sling were available to staff. They accepted that information about the type of sling and which loops to use were not contained within people's care plans.

We also observed that two separate staff members pushed a person in their wheelchair on separate occasions without ensuring that the person's feet were on the footplates. Footplates are used to increase the person's comfort and to reduce the risk of harm to the person. This placed the person at risk of avoidable harm.

Staff could not always provide us with information in regard to the care and support some people needed. Not all staff were able to identify which service users were at high risk of falls or what measures were in place

to reduce the risk of harm from falling. We asked one staff member how they knew which people were at risk of falling and were told, "It says it in the care plan but we don't have time to read them." The staff member confirmed that they had not attended falls training at the time of our visit. Another staff member told us that they learnt about people's needs during staff handover. We observed staff handover on two different floors of the service and found that the level of information provided was limited on one of the floors. This meant that staff were not always provided with appropriate information or training which would enable them to mitigate risk factors. This placed people at risk of harm.

The manager told us that since our last comprehensive inspection, external agencies had provided training in moving and handling and falls management. Records showed that almost all of the staff had completed training in moving and handling and a third of the staff had completed training in falls management. The two members of staff who we observed using the hoist had attended training on moving and handling and one of these staff members confirmed that their competency to use equipment was assessed as part of training. This meant that despite training we could not be assured that staff were supporting people to use mobility equipment safely as staff were not always following safe practices.

We looked at the care records of one person who had experienced a number of falls. We found these lacked detailed guidance for staff and risk assessments had not been updated monthly as specified in the care plan. We saw that information from previous falls had not been used to inform risk assessments and provide further guidance to staff. This meant that the provider had missed opportunities to learn from previous incidents to ensure appropriate safety measures were in place. In addition, there was no evidence that the person had been referred to the falls team for guidance as to how the risk of harm could be reduced.

We were provided with a list of people who lived at the service. This list was inaccurate and we also saw that a number of people's bedrooms were not clearly identified when we looked round the service. A number of agency staff worked in the home who might not have a good knowledge of people who used the service.

We walked into a bedroom and saw that a bag of medicines had been left unattended. A representative of the provider told us that a staff member was currently living in the home and had not locked their bedroom door. This meant that people were put at risk of taking medicines that were not meant for them.

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

The regional manager told us that they would ensure clear guidance would be provided to staff in future about the types of sling to use for different transfers and which loops to use and that further training dates had been arranged to ensure staff were provided with appropriate training on falls management.

People had risk assessments in place in respect of falls which determined their level of need. We saw that these had generally been completed and updated following any falls. We saw that the manager kept a monthly record of falls which had occurred within the service and checked accident and incident forms. If people required safety equipment, such as fall sensor mats, this was provided.

Records confirmed that checks of equipment were carried out on a regular basis to ensure it remained safe to use. We saw records which showed that regular checks were carried out on equipment such as the nurse call system, wheelchairs, hoists and slings. In addition, sensors in people's rooms were checked on a twice daily basis. We saw some occasional gaps in recording on some of these checks and could not locate sensor check forms for one person who had this equipment in place. The senior carer on duty looked for these and confirmed they could not be found. A new form was introduced following our feedback to ensure checks

were being carried out.

If people required regular repositioning in order to prevent a pressure ulcer developing, records were in place to evidence the person was being supported to change their position in line with their care plan. Where people required specialist equipment, such as a pressure relieving mattress, this was provided and was at the correct setting for the person. Records showed that other required safety checks, such as those on fire alarms and water temperatures were being carried out on a regular basis.

The majority of people we spoke with told us there was either not enough staff or there were delays in staff responding to their needs. One person told us, "[Staff] are overworked. They always grumble. I was really annoyed the night before last. I asked them to put me to bed at 6pm. It was 10.15pm when I was eventually put in. But last night two girls came from another floor to put me to bed at 6pm." Another person said, "It ought to be better staffed. Bedtime is the worst for getting help. We've had a lot of changes in staff too."

Records showed that staffing levels identified by the provider as being required to provide safe care to people were generally being maintained. At the time of our inspection agency carers and nurses were being used to fill staffing vacancies. The provider told us that they have now recruited to all vacancies with the exception of two night time carers and they are waiting for employment checks to be completed before new staff can commence working at the service. Although staff confirmed that staffing levels were being maintained the majority of staff we spoke with on one floor of the service felt that additional staff were required. Comments from staff included, "Activities sometimes suffer, we don't get time to sit with residents", "They need to employ more staff. In the morning it is especially busy" and, "Sometimes people have to wait for personal care or to go to the toilet because there aren't enough staff."

During the inspection we observed that people's requests for assistance were mostly answered in a timely way and care and support was delivered in a calm and supportive manner. Call bells were answered promptly. However, people's comments suggested that staff were not always available to meet their needs in a timely was especially in the evenings.

People could not be assured that safe recruitment processes were followed to protect them from the risk of receiving care from staff who may not be fit and safe to support them. We checked the recruitment records of four members of staff. There was not always confirmation that checks through the Disclosure and Barring Service (DBS) had been carried out or that information returned had been considered to determine whether the person was suitable for this kind of work. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults.

In addition we found that although a minimum of two references had been sought these were not always provided from the person's most recent employer or from a person in senior management. The suitability of the references provided had not been considered in determining whether the person was safe to commence working at the service. In addition, people had not always provided an employment history or accounted for any gaps in their employment. The manager confirmed that three of the people had been recruited prior to them coming into post. We saw that an audit of recruitment and induction records was being carried out prior to our visit and had identified some gaps and further information was being sought. However, the audit had not identified all the areas of concern we found during our visit.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last comprehensive inspection on 16 and 17 August 2016, we asked the provider to take action to

ensure that people were cared for in a way that protected them from risk of harm. This was because systems were not effective in reducing the risk of abuse to people who lived at the service. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that improvements had been made.

People told us that they mostly felt safe at the service. Some people reported being disturbed by other people who lived at the service entering their room without their permission but told us of the action that the provider had taken to reduce this occurrence. One person told us, "I feel fine now that they (staff) moved me downstairs to avoid people wandering into my room." Another person said, "It's safe. Occasionally people come in at night and disturb me. They put a (member of staff) on the corridor but they still do it." One person's relative told us that they thought their relative was safe and they had, "Total peace of mind."

People could be assured that staff understood their responsibilities to respond to any incidents or allegations of abuse. Staff had received training in safeguarding adults and the staff members we spoke with told us about some of the different types and signs of possible abuse and the action they would take if they suspected abuse was happening. This included speaking to senior members of staff and reporting their concerns to outside agencies if required. Staff were confident that people at the service were kept safe from the risk of abuse and that the manager would take the required actions following any reports of suspected abuse. One member of staff told us, "I have no concerns about people's safety." Information was also available within the service to give guidance to people and their relatives if they had concerns about their safety. The manager was aware of their responsibilities to report concerns about possible abuse and had shared information with the local authority as appropriate.

At a focused inspection on 3 November 2016, we asked the provider to take action to ensure that people received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were supported to take their medicines at the time they required them. Whilst most people we spoke with told us that a member of staff stayed with them whilst they took their medicines, three people told us that on occasion, they had been left with their medicines to take in their own time. One person told us, "They (staff) don't always wait. They'll trust me to take them after I've had something to eat." We checked the care plans of two of these people, neither of the care plans referenced whether the person was safe to take medicines unsupervised. We spoke to a member of staff who told us that they would always wait with people whilst they took their medicines. This meant that there was a risk that not all staff ensured people took their medicines as prescribed and people's safety to take medicines unsupervised had not been assessed.

During our visits, we observed that people received their medicines when they required them and staff stayed with the person whilst they took them. People received their medicines from staff who had received training and a new member of staff who was shadowing medicines administration told us they would not administer medicines until they had been assessed as competent to do so.

Each person's medicines administration record (MAR) had a photograph of the person to aid identification, a record of any allergies and details of the person's preferences for taking their medicines. When medicines were handwritten on the MAR they were signed by two staff to indicate they had been checked for accuracy of information. When medicines had been prescribed to be given only as required rather than regularly, protocols to provide the additional information required to ensure they were given safely and consistently, were in place for most medicines.

We found a large number of gaps in the MAR's indicating either staff had not administered people's medicines on occasions or they had not signed for the administration. We checked the medicines for one of these people and identified that their morning medicines had not been given on one occasion. Records did not confirm that staff had always checked a person's pulse before administering a medicine that required a person's pulse to be above a certain level to ensure it was safe to be administered. This meant that medicines were not always being managed effectively to ensure people received them safely and as prescribed.

Arrangements were in place for the safe storage of medicines. However, there were gaps in the daily temperature records for the medicines fridge and room where medicines were stored in. this meant that appropriate checks were not always being carried out to ensure that medicines were stored at a correct temperature to ensure their efficacy. Liquid medicines and topical creams were labelled with the date of opening.

As we had previously issued a requirement notice at our November 2016 inspection, the provider had produced an action plan and the date by which they told us they would be compliant had not passed at the time of our visit. We will check their compliance with this regulation at our next inspection.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in August 2016, we identified that staff had not received appropriate training and support since commencing work at the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that improvements had been made to the training and support that staff received although we were not always assured of the competency of staff following training.

People and their relatives told us that they thought that staff were competent in their role, with the exception of some staff members use of the hoist. People's comments included, "They seem well trained", and "The regular staff are good." One person's relative told us, "The team of carers up here now (the second floor), I can't praise them enough."

We spoke to a recently recruited member of staff who confirmed that they had completed online training before commencing work within the service and was in the process of completing their induction booklet. Newly recruited staff confirmed that they spent a period time shadowing experienced colleagues before they began working unsupervised and we observed that a member of staff was shadowing a colleague during one of our visits. The manager told us that all new staff were subject to a probationary period during which their performance would be reviewed.

Training records showed that the vast majority of staff had completed training which the provider had identified as being mandatory. These courses included health and safety, fire safety and dementia awareness. Staff confirmed that they had attended a lot of training in the last three months. The staff we spoke with were complimentary of the training that had been provided by external providers such as the falls team. One staff member described it as, "Eye opening" and another staff member told us they had, "Learnt a lot." The registered manager told us that some staff had yet to attend this training and that further dates had been arranged for 2017.

Not all of the staff we spoke with had received supervision since they commenced working at the service. One staff member told us they had not received supervision since they commenced working at the service at the start of 2016. Two other staff members confirmed that they had received a recent supervision and we saw records which confirmed this. The manager was aware that a large proportion of the staff had not received supervision for a significant amount of time. They showed us a supervision plan which had been commenced prior to them coming into post and an example of a recent supervision they had carried out with a member of staff.

Despite the above, staff told us that they felt supported in their role. One member of staff told us, "I can approach the manager if I need to." Another member of staff said, "I have had supervision. The managers are better and act on issues. I can request training if I feel I need it." We were told by the regional manager that a staff Q and A scheduled during our inspection would be used to discuss our feedback in relation to moving and handling.

People told us that staff asked their permission before providing care and were given choices. One person told us, "They ask us before doing things to help." Another person told us, "They (staff) always ask me if I'm ready to do something," and "We get a choice of two things at lunch or can ask for different. They did me a salad the other day." We observed that staff respected people's decisions and on most occasions asked people's permission before providing care.

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.

Staff displayed an understanding of the principles of the MCA. They confirmed that they had received relevant training. One staff member explained that people were able to make their own decisions if they had capacity and that most people would be able to express a preference or make a choice. They told us that best interest decisions were in place for people who lacked capacity.

We checked people's care records and found that when people were unable to make some decisions for themselves, most people had mental capacity assessments and best interests in place. However these were not in place for all decisions and sometimes lacked detail. We identified that two people did not have mental capacity assessments in place in relation to medicines. One of the people received medicines covertly and although written confirmation had been received from the person's GP which determined it was appropriate for the person's medicines to be administered in this way, there was no documentation to confirm that the person's capacity had been assessed and that this decision had been made in their best interests. The registered manager told us that they would ensure that the relevant documentation was completed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

DoLS applications had been made for a number of people who used the service. We checked the records of a person who had a DoLS authorisation in place and saw that they were receiving care in line with the authorisation. However, for another person the level of restriction deemed necessary to protect them from harm had changed and there was no evidence that an urgent application had been made or that advice had been sought from the local authority regarding the changes.

Some people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms in place which had been completed by external healthcare professionals. However, two of these had not been fully completed and staff agreed to contact the relevant professionals so that these could be reviewed.

People told us they were supported to maintain their nutrition and hydration and were generally positive about the quality and choice of food. One person told us, "They're lovely meals. I've put on weight being here." Another person said, "It's good food. I've no complaints." One person's relation also thought their relative was supported well by staff to maintain their nutrition, stating, "[Relative] is on supplement drinks and will try little bites to eat. They (staff) try [relative] with all sorts."

We observed a mealtime on all three floors of the service. People received their meals in a timely manner and staff ensured that people's meals did not go cold. Where people required physical assistance to eat their meals, this was provided in a respectful and supportive way by staff. We observed on one floor of the service that people may have benefitted from additional prompting and encouragement from staff to eat their meal. We saw that the meal was presented well and a good portion size. People commented following the meal that they had enjoyed the food.

People told us that that they got plenty to drink throughout the day. We observed this to be the case during our visits. We saw that people in communal areas were regularly offered a choice of drink and that people who spent time in their rooms had a supply of water or squash in their bedrooms. Some people required the amount of food and fluid they consumed within a day to be monitored. Fluid charts showed that people were being offered regular drinks although fluid totals had not always been completed to ensure that staff could promptly identify if people were not getting enough to drink.

The monitoring of people's weight within the service was sometimes inconsistent. People's care plans specified whether people were at risk of weight loss and how often they required their weight should be checked for any changes. Records of people's weights were available for most people and showed people's weight to be stable. We saw that one person's weights had not been recorded each month which meant there was a greater risk that staff would not promptly identify any weight changes to determine whether further action was required. The manager told us that people's weights were included in their monthly monitoring of the service and they were confident that people's weights were being monitored. We saw that a new weight recording sheet had been introduced on one floor of the service to ensure consistency of recording.

People, and their relations, told us that the support of healthcare professionals was provided if needed. One person told us, "I see the optician every six months here and the chiropodist every two months I think." Whilst another person said, "The nurse here is very helpful. I've had dental and eye checks." People told us that staff arranged for them to see the GP when this was required.

Care records contained evidence of involvement with other professionals in the person's care, such as the GP, dementia outreach team and occupational therapist. We spoke to four visiting healthcare professionals during our visits, the majority of feedback we received from professionals was positive. One external healthcare professional praised the work of staff in acting on the advice given to them which had resulted in positive changes to a person's healthcare condition.

Good

Is the service caring?

Our findings

People we spoke with were generally complimentary about the caring attitude of staff. One person told us, "They're very comfy to be around and caring," whilst another person said, "They're nice folk mainly." One person's relative told us, "They're lovely, regardless of who's on, they're all equally good." The relative went on to describe the caring actions of the domestic staff towards their relation. Another person's relative told us that staff were sociable and kind.

We observed that staff had positive relationships with people who lived at the service. We saw that staff interaction with people improved throughout the duration of this inspection. On earlier visits we observed that staff sometimes missed opportunities to engage with people who lived at the service. By the end of our inspection, staff were more engaging with people and we saw that people benefitted from increased stimulation and interaction. Staff spoke about people warmly and were responsive to any distress. We observed that a person spilt their tea and a member of staff was quick to mop up the spillage and tell them not to worry. We also observed two staff members discussing a person's low mood and measures they could take to address this, such as spending some one to one time with them.

We saw staff asking people for their preferences and giving people time to respond or giving them verbal prompts, such as showing them the options available. When a person had difficulties in communicating verbally, communication care plans were in place and provided information for staff on how to understand the person's wishes and strategies staff should use to maximise the person's understanding and enable them to indicate their wishes.

People confirmed that they felt at ease with staff and that staff provided support but also encouraged people to do as much as they could for themselves in order to maintain their independence. One person told us, "They let me do what I can and choose what to wear," whilst another person said, "They let me do what I can to keep busy."

Staff were generally knowledgeable about people who lived at the service. We spoke with one member of staff who was able to describe how they supported one person with their mobility and to maintain their nutrition. Another member of staff told us about one person's background, family relationships and likes and dislikes. We saw that one person's care plan identified that they liked classical music and when we checked on this person who spent their day in bed, we found that classical music was playing.

None of the people we spoke with could recall being involved in any review meetings of their care or having their care records discussed with them. However, we saw that a care review had taken place for a person living at the service and they had been involved in the review. The manager told us about two other people who had met with staff to discuss the information they wanted in their care plans, however, they acknowledged this had not been clearly documented.

People's relatives told us that they were kept informed about any changes in their relations healthcare condition. One person's relative told us, "We get to have chats but not meetings. They (staff) ring me too if

[relative] is poorly." Another person's relative said, "I feel like they (staff) are more approachable now. They tell us how [relation] is today when we arrive." People's relatives told us that they were able to visit their relation unrestricted and we observed this to be the case during our visits.

Details of an advocacy service were available with the home. Advocates are trained professionals who support, enable and empower people to speak up. An advocate had visited the home to hold group sessions to help identify and concerns that people may have. The manager was fully aware of the different types of advocacy available and had identified in a care plan audit that one person would require the support of an advocate with any medical treatment decisions.

People we spoke with told us that staff treated them with dignity and respect. One person told us, "They (staff) knock even when my door's open and the curtains get closed every time (during staff support with personal care) as well as the door." All of the people we spoke with reiterated that staff knocked on their doors, ensured that care was provided in a dignified manner and spoke to them politely.

We saw staff supported people to maintain their personal hygiene in a discreet manner and that staff knocked on people's doors before entering. People told us that they were able to spend time privately as they wished. The staff we spoke with were knowledgeable about the values of privacy and dignity and gave examples of how this was promoted and respected by staff.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection in August 2016, we found that people did not always receive care that was responsive to their needs and activities required improvement. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that further improvements were required.

People expressed mixed views as to whether staff provided care in the way and at the time they required it. One person told us, "They (staff) do what they can when they can. The rest of the time I'm alone." However, another person told us that staff had time for fun and laughter and knew them well. One person told us that not all of the staff were aware of the support they required and that they altered their routines in relation to the staff that were on shift. They told us, "They (staff) sometimes seem not to know us personally and don't sit me upright enough to eat and drink." Another person told us that they altered the time they went to bed so that they would not have to wait too long. People's relatives also provided mixed feedback on whether staff had time to spend talking to their relation.

People also told us that they sometimes had to wait for assistance. The majority of these comments related to assistance required in the evening. One person told us, "They're not very quick – they tell me they'll be back later. Last night I kept my buzzer on and it was a good half an hour before they came. I wanted my pad changing as I was getting sore." Another person told us, "The other night I waited over an hour in the evening for them to take out my hearing aids and turn them off. I rang at 10.15 and it was 12.00 before someone came who knew what they were doing. A man had come earlier but didn't know how to take them out." This meant that people may not receive care in the way or at the time they required it.

Each person had a range of care plans to provide information on their care and support needs. We found that these were not always accurate or provided enough information to inform personalised care. For example, one person's care plan stated that they were receiving supplements because they were at risk of weight loss. A staff member told us that they were no longer receiving supplements because they did not like them. They also had a diabetes care plan but this did not provide any guidance for staff on the signs and symptoms of high or low blood sugars and the actions to take. This meant that people's care records did not always contain clear guidance for staff about the individual needs of people they were supporting and how best to respond. In addition, staff told us that they did not always have time to read people's care plans which presented a risk that when care plans did contain detailed information, staff may not be aware of people's individual needs.

People could not always be assured that they would receive support which was personalised to their needs and preferences. We spoke to one person's relative who told us that their relation was a poor sleeper and how they used to spend their time when they couldn't sleep. We saw that this information was not included in their care plan and staff were not aware the person was a poor sleeper and how they had previously spent their time during the night. We also saw that information about people's preferences was not always used by staff to tailor support to people's individual needs. For example, although we saw signs on people's doors stating that they only wished to be supported by female members of staff; people told us their wishes were

not always respected. One person told us, "I said I want ladies only. Men still turn up and I have to turn them away and they say they'll find a female."

We looked at the care records of two people who could display agitation. The guidance provided to staff in one person's care plan was, 'Leave [person] to calm down and return later.' This did not contain sufficient detail for staff to be able to recognise the signs of agitation, any triggers to their agitation or preventative measures. A number of incident forms had been completed for another person who had hit staff and displayed intimidating behaviour towards other people who lived at the service. The person's care plans and risk assessments had not been updated following incidents. It was not clear whether the measures taken by staff such as the use of medicine or restraint were a proportionate and appropriate response. This was because information within the person's records which could have been used to inform staff approach had not been taken into account. This meant there was a clear failure to assess the person's needs and use the information available to provide individual support which was least restrictive of the person's rights.

Staff were not always responsive to the individual needs of people living at the service. We spoke with a visiting healthcare professional who told us they had advised staff to use a visual prompt to help manage a person's agitation. Staff were aware of the prompt and where it was normally situated, however this was not in place on two of our visits. We also observed that another person was supported by a member of staff who was a potential trigger for an escalation in their aggression. We saw that other staff members were available who the person responded to well. We witnessed two incidents that involved the person getting very agitated which presented a risk to the staff member. This need not have happened if the original incident had been responded to appropriately and the escalation of events resulted in negative outcomes for the person.

People's daily records did not always confirm that people had received care and support as specified in their care plans. For example, in relation to daily nail care or regular observations. We saw that some people were on regular observations to ensure their safety. Whilst records were in place for most people which confirmed care plans were being followed, there was no record of 15 minute observations for one person, as specified in their care plan, during the morning of one of our visits.

The manager confirmed that the service was in the process of rewriting all care plans. At the time of our last visit, we were told that 18 care plans had been rewritten. The care plans which had been rewritten were an improvement on older versions but did not always contain detailed and personalised guidance for staff or in other instances the guidance provided was not followed by staff.

All of the above information was an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People provided mixed feedback on the activities provided at the service and the information and encouragement they received in relation to these. Some people told us they enjoyed the activities on offer. Other people told us they chose not to participate and remain in their room. One person told us, "I put music on in the lounge or we have a film on the TV. We had a choir in the other day and I was down at the front singing with them. It was lovely." However, another person told us, "I'll join in if I want to but I don't see much going on."

The service had a dedicated activities co-ordinator who organised activity sessions on different floors in line with a timetable. They provided materials and ideas to care staff to engage with people who did not want to or were unable to join in with the main activity. During our visits, we saw that people were supported to make Christmas cards and decorations and a residents meeting was held where people's ideas for the

service and any concerns discussed. We observed care staff using picture cards on one floor of the service which encouraged people to talk about their memories.

The activities co-ordinator told us that in addition to providing activities in the communal areas of the three floors at different times throughout the week, they set aside two days to provide 1:1 activities with people in their bedrooms if they wished. None of the people we spoke with could recall 1:1 time being spent with them in their rooms. However, we did see that people were provided with 1:1 support to go to the shop if they wished.

Staff told us that the activities co-ordinator visited the different floors two to three times a week and that the rest of the time they were provided with resources to engage people with activities. Some staff members told us that they did not have time to engage people in activities. This meant that people may not always be supported to join in activities or spend time engaging with staff. The manager told us that ideas for activities were discussed at residents meetings and that they had ideas to facilitate trips out and have 'theme nights' at the service.

People felt able to say if anything was not right for them. People told us that they knew how to complain and had done so in the past. During our visits, the complaints that people spoke to us about were historic or were related to concerns that had been raised and were being addressed. One person's relative told us, "They (staff) definitely listen and any grouses are taken notice of."

The service had a complaints procedure and information was available within the home about how to make a formal complaint. No formal complaints had been received since our last inspection; however, the manager had recorded any concerns raised with them. The manager had recorded the action taken to address any concerns, such as meeting with the complaint and replacing items which had gone missing.

Inadequate

Is the service well-led?

Our findings

During our last comprehensive inspection in August 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems in place to monitor the quality of the service were not effective which had resulted in multiple breaches of regulations. During this inspection, we found improvements were still required and the regulation had not been complied with.

The provider had a system to regularly assess and monitor the quality of service that people received. For example, medicines audits had been completed following our last comprehensive inspection. However, the actions identified to address the issues were not always effective. Internal and external audits had previously highlighted gaps in people's medicines administration records. We checked medicines administration records during this inspection and found gaps in 17 people's MAR charts during December 2016. The provider had previously identified an action to reduce the risk of people not receiving their medicines as prescribed. This had not proved effective and no further action had been taken until our feedback, to revise the action plan to reduce the risk to people.

We found several areas of concern with the staff recruitment process. The manager had identified this as an area of improvement and had taken some steps to address issues found following an internal audit. However, the audit had not identified all of the areas of concern we found during this inspection, such as gaps in employment history and the suitability of references. Action was taken following our feedback to ensuring that the risk to people as a result of unsafe recruitment was reduced.

We saw that audits had also been undertaken to monitor quality in other areas of the service, such as infection control, finances and care plans. However, not all the issues we identified during this inspection had been identified and responded to. For example, whilst action had been taken to ensure people had individual slings, by the last day of our inspection on 20 December 2016 care plans did not contain detailed guidance about the type of sling required and how these should be attached to the hoist. This was despite us providing feedback following our visit on 30 November 2016 that staff required more detailed guidance about the type of equipment people required and how this should be used safely. This also meant that timely action had not always taken in response to feedback from external agencies.

We issued a warning notice following our comprehensive inspection on 16 and 17 August in respect of Regulation 17. We found that some aspects of the warning notice had not been complied with. For example, mental capacity assessments and best interest documentation had not always been completed when required. People were also at continued risk of not receiving the correct care and support because their care records did not accurately reflect the care and support they required. This meant that improvements had not always been made and sustained following inspections by external agencies.

The manager told us that they had oversight of accidents and incidents which occurred in the service. During our visit on 30 November 2016 we identified that there was not always documented evidence to show that the manager had reviewed actions following individual incidents to ensure these were effective in

reducing risks. Following our feedback, the manager reviewed accident and incident forms. However during this inspection we found that not all of information available in people's care records had been considered in order to reduce risks to people. We made the manager aware of an accident that had occurred that had not been shared with them. This meant that the system in place to provide effective oversight and take necessary action in relation to accidents and incidents was not always effective. After we had brought this to the manager's attention they introduced a new system to ensure that accident and incident forms were stored and shared with them appropriately.

All of the above information was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives commented positively on the atmosphere of the service. Comments included, "It's a pleasant place," and "I find it smiley and happy here." Two people's relatives commented on positive changes since out last comprehensive inspection. These included, "I am more positive now" and "It seems to be slightly better now. More people (staff) are around and the new manager too."

Staff were also positive about the changes within the service. One staff member told us of improvements within the service such as better staffing levels and confidence in the management team to respond to any issues. They described managers as being, "On the ball" and acting on issues. Another member of staff told us, "I like working here. The staff are lovely and we work well as a team. Communication from management is good." A third member of staff described how they felt supported by the clinical lead when they had dealt with a situation which was new to them and had received positive feedback on their actions.

The manager told us that they were well supported in their role by representatives of the provider including a regional manager. They told us that they were in regular contact with the regional manager who visited the service regularly and carried out monthly audits at the service. Records confirmed this to be the case.

Since our last comprehensive inspection, we saw that a number of meetings had taken place with staff, people and their relatives. Staff confirmed that they had attended staff meetings and felt able to raise any issues or concerns they had or make suggestions. Staff told us that they felt listened to. We saw that a staff 'Q and A' was taking place during one of our visits. The manager told us that the meeting was an opportunity for staff to ask questions and get the information they needed. The regional manager also told us that the meeting was used as an opportunity to give staff the confidence to take more responsibility for driving improvements at the service by supporting each other.

Although people's awareness of how they could give feedback about the service was not high, we saw that people's views were sought in developing the service. People told us that they were not aware of any meetings where they could give their feedback about the service or make suggestions. However, we saw that a residents committee meeting was being held during one of or visits. The meeting was attended by approximately a quarter of the people who resided at the service at the time of our inspection. The meeting was facilitated by the activities co-ordinator and people were given the opportunity to comment or make suggestions regarding their safety, cleanliness and maintenance of the building, activities and the menu. We saw that issues raised during the meeting had been responded to immediately or were shared with a senior member of staff.

People who lived at the service were not aware of any recent surveys where they could provide feedback on the service. The manager told us that a recent survey had been carried out with relatives by commissioners of the service. They were awaiting the results of the feedback but had been told that it was mostly positive about recent changes at the home. We saw that a suggestion box was available in the main reception area

of the home and the results of a previous survey were displayed in a prominent position. The relatives we spoke with were aware of recent changes within the service even if they had not been able to attend meetings. One relative said, "They do have meetings but it's usually when I can't get there. They (staff) tell me verbally what's happening. The last meeting was about the home and the way it was going forward and improvements."

At the time of our inspection there was not a registered manager in post. The registered manager had stopped working as the manager in May 2016. Interim management arrangements had been in place until the new manager had commenced working at the service approximately a month before our inspection. People and their relatives were aware of recent changes in management at the service. Staff told us that the manager was visible around the service in addition to other senior members of staff. One staff member told us, "The manager comes up; they are always on the floor. [Clinical lead] is always up here and has a handle on the floor. We usually have a senior on shift. There is always a senior member of staff on call. The on call is always answered."

We found staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures without fear of recrimination. We also found the management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC). Our records showed we had been notified of incidents that had occurred within the service since our last inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff had not always been recruited following safe recruitment practices.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was responsive to their needs and preferences. Care records did not always contain detailed and current information for staff.

The enforcement action we took:

We have issued a Notice of Proposal to impose conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always safely supported with their mobility. Potential safety hazards had not always been identified and responded to.

The enforcement action we took:

We have issued a Notice of Proposal to impose conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality of the service provided were not effective in responding to issues in a timely way. Information and feedback was not used effectively to drive continuous improvements at the service.

The enforcement action we took:

We have issued a Notice of Proposal to impose conditions on the providers registration.