Veecare Ltd

High Meadow Nursing Home

Inspection report

126-128 Old Dover Road
Canterbury
Kent
CT1 3PF

Tel: 01227760213
Website: www.veecare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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 1 and 2 March 2017 and was unannounced.

High Meadow is registered to provide nursing and personal care for up to 34 people .There were 28 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, Parkinson's, catheter care, dementia; and people who needed support to be mobile. Many people were nursed in bed.

High Meadow is a large detached premises situated on the edge of the city of Canterbury, Kent. The service had a very large communal lounge/dining room; with armchairs and a TV for people and a separate, quieter conservatory. Bedrooms are situated over three floors; with a passenger lift available.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

High Meadow was last inspected in January 2016. At that inspection it was found to require improvement. There were a number of breaches of Regulation and we issued requirement actions about these. The provider sent us an action plan showing that all of these areas had been improved. At this inspection however, we found that none of the Regulation breaches had been fully addressed. In addition, other issues had emerged, resulting in further breaches of Regulation.

Assessments had been made about individual risks to people but actions designed to minimise these were not always adequate in practice. This related to diabetes and pressure wound management and the risks of people being isolated and unable to use call bells to summon staff.

Staff were sometimes neglectful of people's need to use the toilet, asking them to wait for up to 30 minutes while other tasks were completed. There were not enough staff on duty to meet people's needs, and staff training could be improved in some areas.

Dietician advice was not always followed to ensure people received adequate nutrition and staff were not aware of target fluid intake for individuals. Records about food and fluids were filled out in retrospect and were sometimes found to be inaccurate.

Staff were not consistently caring and some had become desensitised to people's calls for assistance. There were scant records about people's hopes and wishes for the end of their life. There was not enough interaction or stimulation for people who stayed in bed every day.

Quality assurance processes had not picked up and addressed the issues we found during this inspection.

Effective action had not been taken following our last inspection to make positive changes and provider oversight had been inadequate. A poor culture had developed in which staff had become desensitised to people's needs.

Medicines were well-managed and safely administered by staff. The service was maintained to a good standard and all equipment was routinely safety checked.

People's consent had been sought formally and verbally for day-to-day care tasks. Staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and worked within its principles. The registered manager had made applications for deprivation of liberty safeguards (DoLS) and received authorisations for some of these.

Staff received regular supervision and appraisal. There was a robust recruitment system in operation and all necessary checks had been made prior to taking on new staff.

There was a system for recording all complaints and people and relatives knew how to raise concerns. Feedback was sought through a variety of sources.

The registered manager was respected by staff who described good teamwork.

We recommend that the provider obtains from a reputable source; information about first aid during and after seizures.

We recommend that the provider seeks professional advice about best practice guidelines for people's individual fluid intake.

We recommend that the provider ensures that people's hopes and wishes for the end of their life are individually discussed and documented wherever possible.
We found a number of breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of people's diabetes was not safe as staff lacked the knowledge to escalate concerns quickly.

Actions to minimise known risks to people had not been consistently taken.

There were not enough staff deployed to meet people's needs.

People were not consistently protected from abuse or neglect. Medicines were safely managed.

Recruitment processes were robust and helped ensure the suitability of applicants.

Environment and equipment safety checks had been regularly undertaken.

Is the service effective?

Requires Improvement

The service was not always effective.

Some aspects of people's healthcare had not been effectively managed.

Staff had received a range of training but needed further, specific courses to support them in their roles.

People enjoyed a choice of meals and received support to eat them but records of people's intake were not always accurate.

Staff understood the principles of the Mental Capacity Act (MCA) 2005 and acted accordingly. Deprivation of Liberty Safeguards (DoLS) applications had been made when necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff sometimes told people that their needs were not a priority

which made some people feel they were being a burden.

Work was needed to ensure that end of life hopes and wishes were documented and staff trained in best practice in this area. People's privacy and right to confidentiality were respected.

Staff encouraged people to be independent when they were able.

Relatives reported feeling involved in their loved ones' care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provision of activities had not improved and people who stayed in their bedrooms received little social interaction.

Care plans were well-presented and written but care delivery was not always person-centred.

There was a complaints system in place and people and relatives knew how to voice concerns if necessary.

Is the service well-led?

Inadequate

The service was not well-led.

Issues identified at our last inspection had not been properly addressed.

Quality assurance processes and provider oversight had failed to identify shortfalls in further areas.

A poor culture had developed which did not support person-centred care.

Feedback had been sought from people and relatives.

The registered manager was approachable and visible in the service and people, relatives and staff said they could speak to them about concerns.

High Meadow Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 March 2017 and was unannounced. An inspector, a specialist nurse advisor and an expert by experience carried out the inspection. The specialist nurse advisor had nursed older people and the expert by experience had personal experience of caring for older people living with dementia.

Before our inspection, we contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. A Provider Information Return (PIR) was completed by the provider but had not been received at the time of this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We met with fourteen of the people who lived at High Meadow. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with six people's relatives during and after the inspection. We inspected the service, including the bathrooms and some people's bedrooms. We spoke with three nurses, five care workers, kitchen staff, the registered manager and the provider.

We 'pathway tracked' ten of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and

made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

Many people were unable to tell us about their experiences of living in the service, but we received mixed feedback from those who could speak with us, and their relatives. One person told us "Staff just don't come to me; I call or press my buzzer but I'm just left for a long time". Another person said "It's okay here I suppose; that's about all I can say". A relative however, told us "We chose this place after looking at lots of different homes and feel it's very safe here". Another relative remarked "[Person's name] is safe here-it's a lovely place and you won't find much wrong here".

At our last inspection we found that clear protocols were not in place about treating high or low blood sugar levels for people living with diabetes. At this inspection new protocols had been introduced and were much more detailed. However, during the inspection one person's blood sugar levels were found by nursing staff to be high when they were tested at lunchtime. We asked staff what further actions they would take in this situation and they told us that they would check this person's blood sugar again at around 4:30pm. This was too long a gap between blood tests and created a risk that the person's blood sugar could increase significantly in that timeframe, leading to an emergency situation. The new protocol did not state the appropriate time gap between tests, but the registered manager immediately contacted a specialist diabetes nurse when we brought this matter to their attention. The advice of the diabetic nurse was to re-test blood sugars within an hour following the high reading. Nursing staff had not been aware of this until we highlighted the issue, but the person's blood sugar levels had risen again when tested after an hour. The GP was called at that point but staff had not had adequate instructions to follow to prevent deterioration in this person's condition and keep them safe. Staff did not measure the person's temperature to see if they might have an infection which could affect blood sugar levels nor encourage the person to drink plenty; which is good practice when high blood sugar is noted. Although nursing staff told care staff not to give this person a pudding after their lunch, we observed that they were provided with a bowl of fruit instead. Fruit contains a type of natural sugar called fructose, but staff did not appreciate that this could also influence people's blood sugar levels.

Risks to people from the layout of the building had not been properly minimised. People's bedrooms were situated over three floors and most people were nursed in bed. Some people were receiving end of life or palliative care and most people were unable to use call bells to summon staff assistance. The registered manager told us that hourly checks were made on each person to ensure their safety and well-being. However, records of these checks showed that they had not consistently been made hourly. For example, one person who was receiving end of life care was checked two-hourly on a number of occasions, which meant there were longer gaps than had been assessed as necessary to keep them safe.

The failure to properly assess and minimise risks is a continued breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection protocols about managing seizures were not sufficiently detailed. At this inspection these had been improved but still lacked information about first aid to be given to prevent injury during a seizure and possible choking afterwards. These details were important in ensuring that people were kept

safe during and after seizures.

We recommend that the provider obtains from a reputable source; information about first aid during and after seizures.

During the inspection some people asked repeatedly to be taken to the toilet. Staff were heard on several occasions telling people "We're still feeding other clients, you will have to wait a while" or saying that other people were still getting up so they would need to be patient. One person waited for more than 30 minutes to be assisted and was becoming quite agitated. Other people waited for at least 20 minutes for support. A relative told us "Mum and other residents have to wait to go to the toilet, and that happens a lot. My main concern is about mum's incontinence, I'm not sure how often she should go to the toilet/be changed as she's suffered repeatedly from urine infections. Sometimes she smells of urine". Another relative told us that staff could sometimes be "Dismissive" of people who asked to be taken to the toilet. The registered manager said that people would be supported as soon as possible but that staff had other tasks and people to attend to. They also told us that one person showed a repetitive behaviour of asking to go to the toilet. However, the registered manager was unable to say how they would be able to tell if the person genuinely needed to go.

Staff had all received training about protecting people from abuse and could tell us about some of the forms that abuse might take. However, they did not understand that failing to respond appropriately to people's need to go to the toilet was neglectful.

The disregarding of service users' expressed needs is a breach of Regulation 13 (1) (4) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, there were not enough staff to meet people's needs. At this inspection the situation had not improved. Aside from people's need to go to the toilet being delayed, other people were calling out from their beds for assistance at times. On several occasions Inspectors went to see people because there were no staff available; and one person's visiting relative became concerned about another person shouting for staff and went to comfort them. One person told us they were sometimes left waiting for pain relief because staff were busy doing other things.

There was one nurse and six care staff on duty in the mornings and one nurse and four care staff in the afternoons. At nights there was one nurse and 2 care staff. Of the 28 people living in the service the registered manager told us that 21 people needed support to eat and 27 people needed two staff to assist them to mobilise and with personal care. On the first day of the inspection, 22 people were nursed in their beds although two more people got up on the second day. Eight people were receiving end of life or palliative care. The service is set over three floors, making the correct deployment of staff crucial to ensure people's needs are met. A dependency tool had been used to assess people's needs but this had not taken account of the layout of the building and the need for every person to have at least hourly checks because they could not use call bells.

There were times when there were no visible staff on the first or second floors and some people became distressed or anxious when staff did not come quickly. Although lunch started at 12:30pm, some people did not receive support with their meals until 1:40pm. We received mixed feedback from people and relatives about staffing levels. One relative told us "From what I've seen they come in regularly to check on [Person's name]" but another said "There's not enough staff here" and told us about specific tasks that staff did not carry out for their loved one. One person said "I can wait and wait and sometimes be very uncomfortable, but they don't come or say they'll be back in a minute and never come back". One staff told us that they did

not always have time to take people to the toilet straight away or to stop and have a chat, and another said that people's complex needs meant they needed a lot of time and there were not enough staff to provide this.

We raised our concerns about staffing levels and deployment with the registered manager and the provider during the inspection. The provider told us they would increase staffing by one care staff on each shift with immediate effect and to carry out a revised assessment of people's needs as a priority. Following the inspection we contacted the registered manager who told us that an extra member of care staff had been added in the mornings and afternoons but not at night. They also said that the extra member of day staff worked from 8am until 6pm instead of 8am until 8am, meaning that there was a gap of two hours each day where there was no extra care staff. The registered manager said that reassessments of people's needs were being carried out to determine if more staff were needed.

The failure to deploy sufficient staff is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recruitment system in place. We checked four staff files and found that they each held all appropriate documentation about staffs' employment. This included application forms which detailed all past employments, references from previous employers, identity documentation and criminal records checks. This evidenced that the provider had ensured that suitable staff were employed to work with people living in the service.

Medicines had been managed safely. All medicines were stored securely and correctly and the temperature of the medicines room and fridge were routinely measured. This ensured that medicines were kept within the manufacturers' guidelines. Medicines about which there are special legal requirements were locked away and two staff signed a register to show when people had been given them .Medicines charts had been properly and clearly completed to show when people had received their medicines and staff waited with people to make sure they swallowed medicines before signing off charts.

Detailed protocols were in place for people who had been prescribed medicines such as pain relief to be taken on an as and when needed basis (PRN). This helped staff to understand the reasons why a person might need their medicine and the maximum doses that could be safely taken in a 24-hour period. Medicines for returning to the pharmacy had been logged in a returns book and were regularly collected so that there was not a large amount of unused medicine being kept in the service.

There was a system in place for staff to report any accidents or incidents and staff knew how to do so. However, there were no records available of any incidents as the registered manager told us there had been none since the last inspection. The registered manager monitored falls but there had not been any, given that most people were nursed in bed or used wheelchairs to mobilise which reduced the likelihood of them falling.

Fire safety equipment such as extinguishers, emergency lighting and the fire alarm system had been routinely checked and maintained. All staff had received fire safety training and those we spoke with could point out fire exits and assembly points. Other equipment like hoists, special baths and the passenger lift had regular safety tests to ensure they remained fit for purpose. A maintenance person was employed and they kept records of repairs they were asked to make and when these had been completed. These showed that jobs had been carried out promptly to keep the service in suitable condition.

Requires Improvement

Is the service effective?

Our findings

People and relatives gave us positive feedback about the food on offer. One person told us "The foods very good, no complaints whatsoever. It's excellent". A relative said "The food is really good. Today I'm going to have lunch with [Person's name].There's plenty to eat and it's cooked well".

Some people had been assessed as at risk from poor nutritional intake. In these cases food charts were completed by staff to record what had been eaten. However, these were filled out retrospectively and our observations showed that the details recorded were not always correct. For example; one person was served a cheese salad in their bedroom at lunchtime, but when we visited them at 2:30pm they were asleep and the meal remained uneaten. This person's food chart had not been completed by 3:30pm but the following day it documented that the person had been served roast turkey and vegetables at 12:30pm and that all of the meal had been eaten.
A full or almost full bowl of cereal was removed from another person's room after breakfast as they were asleep. Their food chart was checked the following day and showed 'Cornflakes 100% eaten'. By filling in charts retrospectively, there was risk that staff would forget what each person had eaten, making the chart inaccurate and not providing a proper picture of people's intake.

The failure to make accurate, complete and contemporaneous records is a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people lost weight advice was promptly sought from a dietician. However, their guidance was not always followed in practice. One person had lost weight between December 2016 and January 2017 and was quickly seen by the dietician who recommended food was provided 'Little and often' and that yoghurts and puddings were provided in between meals. Food charts showed that three meals a day had been given to this person with no record of any puddings or yoghurts in between for the whole of February 2017. The registered manager said that this person had started to gain a little weight; but professional advice had not been followed to ensure this happened.

Some people also had charts in place to record how much they had drunk each day. However, no target amounts were recorded in care plans or on fluid charts and staff gave us different answers about how much people should drink to keep them well. Charts had been totalled up and showed that most people were drinking reasonable amounts. Some people who were receiving end of life or palliative care were only able to take sips or smaller amounts, but these had been recorded by staff.

We recommend that provider seeks professional advice about best practice guidelines for people's individual fluid intake.

There were plenty of drinks available to people. Jugs of water and squash were in bedrooms and a tea trolley was taken around several times a day. People appeared to enjoy their meals in the main, and staff supported some people who needed help to eat or drink; although some people did wait more than an hour after lunch started to receive their meals. A choice was available and lunch and supper and picture cards

were used to help people make a decision about what they would like to eat. Where people had been assessed as needing pureed meals or thickened fluids these were provided and staff knew which people had these.

Wound care was not well-managed. At the start of our inspection we asked the registered manager about any current pressure wounds. They told us that three people had grade 2 pressure sores. However, when we checked with nursing staff we were told these had deteriorated to grade 3. Special pressure-relieving air mattresses were in use but the pumps had been set at incorrect levels for some people assessed as at risk of, or having existing pressure sores. Pumps should be set according to people's weight to achieve the most therapeutic benefit, but one person's pump was set to 80kgs when they weighed 55.8kgs and another person's pump was set to 90kgs when they weighed 39.6kgs. The registered manager told us that daily checks were made of the pump settings to ensure they were correct, but when we read records we found the pumps had not been checked since 21 February 2017.

One person whose pump was at the wrong setting was nursed in bed which made them more prone to pressure wounds developing. Their care plan recorded that they should be supported to reposition every two to three hours to help relieve pressure. Charts showed that there had been gaps of up to six hours between repositioning on some occasions. At other times gaps were often four hours and on one chart there was a gap of 10 hours between the times that staff documented that this person had been supported to turn. Another person who was prone to pressure areas had a chart which showed they had last been repositioned at 6am when we checked at 12pm. This had not protected people from the risk of their wounds worsening or causing them discomfort.

The failure to properly minimise risks is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager re-referred three people to the specialist tissue viability nurse during the inspection.

None of the staff had received training in specialist subjects such as diabetes, end of life care, wound care or nutrition. Our inspection found that lack of specific training in these areas affected the quality and safety of the care people received. There were three people who were dependent on Insulin to control their diabetes, eight people were receiving end of life or palliative care, three people with pressure sores and many people needed their nutrition to be monitored. Training would have helped staff to deliver consistently safe and appropriate care to people with special health concerns.

The failure to provide adequate training is a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives said that they were confident in staffs' ability to support their loved ones. One relative told us "I think they're skilled enough; my Mum is quite calm these days". Another relative said "They look after [Person's name] very well and seem to know what they're doing. Nurses are very on the ball". Staff completed a programme of mandatory training and refreshers in a range of subjects to support them in carrying out their roles effectively. Courses included subjects such as; behaviour that challenges, dementia awareness and moving and handling. We observed staff skilfully supporting a person living with dementia and correctly using hoisting equipment to safely transfer another person from a wheelchair to an armchair.

All new staff underwent an induction and participated in 'Shadow' shifts before they were rostered on duty. This meant staff had a good basic understanding about their roles and expectations before they began. Staff received regular supervision to discuss development and training needs and had appraisals annually.

There were no formal pain assessments in place for people who were unable to verbally express pain. Although staff knew people well and could tell us that people's facial expressions and body language would indicate discomfort, there was no proper documentation to record when pain had been assessed, the outcome and whether any changes had been noted; which might require input from the GP. This is an area for improvement.

Other aspects of health care were better managed. Catheter care plans were detailed and gave staff clear directions about how to maintain catheter equipment in a clean and hygienic condition. Instructions were documented about when the catheter and bag should be changed and signs of infection that staff should be aware of. Staff had appropriate guidance to support them in delivering effective care to people using urinary catheters and could tell us how this happened.

Where people had conditions such as impaired sight, there were clear care plans about how people should be supported. This included detailed guidance about day to day care tasks and the use of audio books to prevent the person becoming isolated. Staff had received training about caring for people with impaired sight to enable them to care for people safely and effectively.

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People were able to see a doctor when needed and had access to chiropodists and dental appointments. Professional input was received from dieticians, speech and language therapists, tissue viability nurses and mental health teams to help maintain people's health and well-being. Relatives told us they felt staff reacted quickly if their loved ones were unwell. One relative told us "If [person's name] is ever poorly they get the doctor in quickly from my point of view. They always let me know what's happening too". Another relative said their loved one's health had improved significantly since moving to the service.

People's consent to some aspects of their care and treatment had been formally sought. Verbal consent was sought by staff for day-to-day matters like asking permission to go into people's bedrooms or when giving people medicines. Some people lacked mental capacity to make some decisions and in these cases, a detailed mental capacity assessment had been made. These are necessary to comply with the principles of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making.

Staff had received up-to-date training about the MCA and worked in accordance with it. For example, staff offered people straightforward choices by showing them two sets of clothing. This allowed the person to continue to express their choices, with staff support. A relative told us "Staff are all very helpful, and they encourage [Person's name] to dress but he chooses what to wear, he likes to look good, he's always been well groomed. Some days he needs to be prompted to dress but staff let him make decisions about what to put on". Where people lacked capacity for more complex decisions, we saw evidence that best interest meetings had taken place with family and other professionals, to agree the right course of action to take on the person's behalf.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities around (DoLs) and had made a number of applications to the proper authority.

Requires Improvement

Is the service caring?

Our findings

We received mainly positive feedback about staff from people and relatives. One person told us "Staff are kind enough, they try their best". A relative said "Staff are sweet and so kind; it's been a great weight off my shoulders to have my relative here". However another person told us that they were worried about speaking with us in case they were "Thrown out" but said "They [staff] make me feel like a nuisance when I ask for anything".The registered manager told us that some people had behavioural issues which might affect the feedback they gave us.

Our own observations showed that staff spoke with people in a gentle and kind manner during the inspection. However, the messages they sometimes gave people were less considerate; for example that they could not be taken to the toilet straight away because other people's needs took priority. It was undignified for people to have to ask repeatedly for support to use the toilet in this way. A relative told us "Mum gets upset because she thinks she's being a burden to staff when she has to keep asking for the loo".

Staff had become desensitised to some people's calls for assistance and walked past rooms where people had been shouting out for some time, without offering any words of comfort. Staff were very busy but we found people settled quickly after we spoke with them for a while or held their hand and made conversation about their photos. Most people were living with dementia or had complex care needs and looked to staff for reassurance.

Eight people were receiving end of life or palliative care during our inspection. Most of these people's bedrooms were situated on the second or third floors of the service. While this gave people a quiet and peaceful place to be, it also meant that these people were furthest away from the registered manager's office and the nurse's hub .Some people were calling out for attention during the inspection and there were no staff within hearing distance.

Care plans about end of life only held information about next of kin and funeral arrangements. There was no detail about actions to be taken to make people's last days comfortable and pain-free. The registered manager told us they were re-writing these care plans but at the time of the inspection they did not contain sufficient information to ensure that staff would be meeting people's preferences and wishes or their particular needs at that time. Most staff said they had not received end of life training and one said they had, but found the content confusing. Although all staff talked about "Making people comfortable" none could adequately describe how this could happen in practice.

People were not always treated with dignity and respect which is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff interacted very well with people. Kitchen staff were chatty, kind and respectful when delivering drinks to people and it was clear they enjoyed some light-hearted banter. We observed another staff member supporting a person to eat and this was done with consideration and compassion. Eye contact was maintained and gentle encouragement was offered at every stage.

People's privacy and dignity was respected by staff when they needed personal care. A relative told us "They are very caring and respectful. They treat [Person's name] with dignity; whenever they are changing her or moving her they ask whether she is ok, and they always close the door to give her some privacy". Staff covered another person's legs with a blanket when they were being supported to transfer with a hoist so that they were protected if their clothes rode up during the manoeuvre. Staff knocked on people's bedroom doors and called out before entering to show respect for their personal and private space.

Relatives told us that staff encouraged people to remain independent for as long as possible. One relative told us "Mum is encouraged to feed herself and they help her by cutting the food up for her." Care plans were very detailed and included step-by-step guidance for staff about cleaning people's teeth for example, but supporting them to do this themselves if they were able. Although 22 out of 28 people were nursed in bed on the first day of our inspection, a few more people were supported to get up on the second day and eat and be with others in the lounge area. People looked clean and well-kempt. Some ladies proudly showed us their painted nails and a hairdresser visited on one day of the inspection. It was clear that people enjoyed the opportunity to present themselves in the way they chose as a way of expressing their independence and individuality.

People's care records were kept securely and information was handled confidentially by staff and the registered manager. Care was taken to ensure care files and other documents were not left out where others might read them. Relatives told us that they felt involved in their loved ones' care. One relative told us "Before [Person's name] came here we had a very thorough meeting to plan her care. We talked about her likes and dislikes, about which things she would like around her. I do feel involved and that I'm kept informed about her". Another relative commented "We like to be involved with day to day issues but also get involved with the relative meetings that happen".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that there was not enough social stimulation for people. At this inspection there had been little improvement and people's need for interaction was not appropriately met. The activities coordinator had left on the Friday before our inspection and the provider had recruited another who was due to start work the week after. A member of care staff was working in the role of activities coordinator during the inspection. Two wall planners were displayed on the ground floor but the information differed between them about which activities were on offer each day. This was not helpful for people living with dementia. People sat and waited in the dining area for a promised game of bingo to start. Staff kept saying that the game would start shortly but it did not happen at all. People told us that this often happened and they would be waiting for an activity which was then changed without discussion or did not go ahead. This was inconsiderate and we observed people becoming bored and falling asleep while they waited.

Staff attempted a ball game and a pianist visited for a sing along but most people were in bed and did not benefit from this. On the second day of our inspection a person visited to sell jewellery boxes and trinkets and this was the activity for the afternoon. Again, people in their bedrooms were not involved and they just slept for most of the day or had a TV on. Staff told us that the previous activities coordinator had regularly visited everyone in their bedrooms for one-to-one time and chats but a relative told us "[Person's name] gets about 20 minutes once a week where they are read to or have a chat. I don't think this is enough and people need more stimulation". More interaction may have helped to calm some people who called out repeatedly.

The lack of social stimulation to meet people's needs is a continued breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that special occasions such as birthdays, Christmas and Easter were celebrated in the service and we saw balloons left over from Valentine's Day in the conservatory. A bar area had been set up in one part of the dining room and a 'Sweet shop' in another. However, people were not independently mobile so these areas served a decorative purpose only. Packets of crisps were available in the sweet shop zone but staff would need to give these to people rather than them helping themselves because of their restricted mobility.

Care plans were well-presented and had been written in a person-centred way. There was sensitively prepared information about people's former lives and achievements which helped staff to understand more about people's families and backgrounds. Staff knew people well and could tell us about people's individual personalities. However, care was not always delivered in a person-centred way so that people's specific needs were at the heart of staff actions. For example, one person's care plan documented that they needed encouragement to eat but their meal was given to them to manage on their own; and this person was losing weight. Their care plan also stated that they should be sitting upright in an armchair to eat, but they were lying in their bed with the meal beside them when we visited this person in their room. Another person was meant to do exercises which the physiotherapist had recommended but a relative said this did not happen

regularly. People's care did not reflect care plan assessments and directions in some cases; which meant their needs were not fully or appropriately met.

People's bedrooms had been personalised in most cases, with photos, pictures and other items that were important to them. A relative told us "All [Person's name] clothes are hanging in the wardrobe, it's for her dignity. I'm not sure if she'll ever wear them again but they are there. We also bought in all her own linen and quilt so that she has all her things that she's used to around her".

The registered manager told us there had been no complaints since the last inspection. However, there was a recording system in place so that the registered manager could log any future complaints and document when acknowledgments and final responses were sent. The provider's complaints policy was displayed in the front entrance foyer, giving guidance about how to make a complaint if necessary. All of the people and relatives we spoke with said that they knew how to complain and would approach the registered manager in the first instance. One relative told us they had made complaints in the past and they had been dealt with in a timely way. Another relative told us that several family members had complained about "Scruffy carpets" at a relative meeting and these had been swiftly replaced. Actions were taken when concerns were raised and the relatives we spoke with said they felt listened to.

A number of thank you letters had been received by the service. One of these read 'We wish to convey our heartfelt thanks to you all for your care and compassion', and another said 'Many thanks for all your hard work over the years. We really appreciate the personal attention you gave'.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider's quality assurance processes had not been sufficiently robust to consistently identify and resolve shortfalls in the quality and safety of the service. At this inspection the situation had not improved. None of the issues we raised at our last inspection had been fully resolved. Although protocols had been produced about diabetes management, these did not contain enough information to guide staff properly and keep people safe. There continued to be inadequate levels of staff and people's need for social interaction remained unmet in many cases.

At this inspection we also highlighted that risks had not been monitored or properly mitigated in relation to people being unable to use their call bells, that staff training needs had not been recognised, that record-keeping was inaccurate and created risks to people's well-being, that professional advice was not always followed when people lost weight and that pressure wounds had not been managed in line with best practice guidelines. All of these areas should have been assessed so that risks could be identified and minimised.

Staff reported excellent teamwork and said they enjoyed working in the service. They told us that they felt supported by the registered manager and it was clear they looked to them for guidance. However, a culture had developed in which staff were delaying taking people to the toilet because the registered manager had stated that other tasks must be completed first. Staff did not question this or appreciate that it was neglectful and one of them frankly told us "People have to wait to go until after the breakfasts are done". Some people said they felt like a "Burden" or a "Nuisance" to staff and this regime did not help dispel their worries. The registered manager and provider should have recognised that this was not person-centred care and taken action to rectify the situation. The registered manager told us that there was an ethos of protecting people and not tolerating abuse in the service. They had failed to identify that some staff actions amounted to neglect; including walking past people who were calling for assistance without acknowledging them.

The failure to assess, monitor and mitigate risks to people's health, safety and welfare is a breach of Regulation 17 (1) (2) (b) Regulations 2014.

There had been insufficient oversight by the registered manager and the provider to ensure that these issues were picked up and remedied. A number of audits were carried out but had proven ineffective in identifying where standards had fallen. For example, a pressure ulcer audit had been carried out but did not show the deterioration in some peoples' sores. A provider audit noted that food and fluid 'Intake records updated in a timely manner'; which was contrary to our findings. The same audit noted that people were encouraged to wash their hands before eating, but this did not happen during the inspection and staff said that this was not something they routinely did. No comments had been recorded in the provider audit under the heading of 'End of life care', but we found that training and care planning was lacking in this area.

The failure to operate effective quality assurance systems is a continued breach of Regulation 17 (1) (2) (a) (of the Health and Social Care Act 2008 (Regulated Activities)

A falls audit had been carried out but there had consistently been no falls as most people were nursed in bed or were supported to be mobile in wheelchairs.

Feedback had been sought from people and this had been documented as a service users' meeting with 16 attendees. When we spoke with the registered manager however, we found that they had visited people individually in their bedrooms to ask for their views. No negative comments were raised with the registered manager. There had been a relatives meeting on 21 February 2017 and two relatives attended. Minutes recorded that both relatives said they were satisfied with the care of their family members.

A resident survey was issued in January 2017 and there had been five responses. Some of these had been completed by people with the help of staff. All of the responses rated the service as good or excellent. Staff meetings were held regularly but minutes showed the most recent of these were very brief with no staff feedback noted. The need to wear name badges and mandatory training were discussed but there was no mention of any of the areas of concern we found during the inspection. There was no 'Any other business' section of the meeting to invite staff to give feedback or raise concerns. Staff told us that they felt able to speak out with any concerns however, and had confidence that the registered manager would act upon them.

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Relatives told us that the registered manager was a visible presence in the service and was approachable. One relative said "I see the manager around quite a lot, she's very hands on". Another relative told us "[Registered manager's name] is easy to talk to and she made the move into this home very easy for everyone".

The registered manager is a registered nurse. They told us that they kept up with developments in the adult social care field by attending care home forums, reading information distributed by the Nursing and Midwifery Council (NMC) and completing online training courses as they became available. The registered manager is also completing a National Vocational Qualification (NVQ) level 7 in management. The NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job. However, leadership of the service had not been robust enough so that staff were held to account when care or records about it were not of an acceptable standard.

The service had forged a number of links with the local community; for the purpose of improving the quality of people's lives. A local church attended regularly to give people Holy Communion if they wished and schools sent children's choirs to visit and entertain people at Christmas and Easter.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always met appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People's needs were sometimes disregarded by staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment; assessments about risks were not minimised in practice.

The enforcement action we took:

A warning notice was issued

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 There had been insufficient quality assurance and management oversight in the service.

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to consistently meet people's needs.

The enforcement action we took:

A warning notice was issued.