Caspia Care Limited

Hendford Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 19 April 2016 by two adult social care inspectors.

Hendford Care Home with Nursing is registered to provide accommodation and nursing care for up to 41 people. The home is organised into three units. On the ground floor is Greenwood providing support for people with dementia. On the first floor Silver Birch is mainly for people requiring nursing care. On the top floor is Pine View. People with residential needs and those requiring respite are usually, although not exclusively offered a room on Pine View.

At the time of this inspection there were 24 people living at the home. Twenty one people were living there permanently Three people were having short term respite care.

The previous inspection of the home was carried out on the third of August 2015. The service was rated as Requiring Improvement. The domains safe, effective, responsive and well led required improvement.

A breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 : Need for Consent. was identified. This related to the failure of the service to fully comply with the requirements of the Mental Capacity Act 2005. We received an action plan including timescales when actions would have been completed. At this inspection these had been addressed.

Prior to the inspection some concerns had been raised about the staffing levels in the home and how this was affecting the care provided to people.

There were insufficient staff to meet each person's needs safely. On the afternoon of the inspection there was one nurse and three care staff on duty to meet the needs of the 24 people living there. The demands on the care staff were high and this meant staff were unable to meet some people's needs fully. Staff had insufficient time to provide adequate care and support to people with complex nursing needs and those living with a dementia.

There was no registered manager in post. 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. Interim management arrangements were in place.

Action was taken promptly following the inspection to increase the staff allocation during the day and at night. However time is needed to embed the improved staff ratios and to ensure the staff numbers are managed effectively so that improvements to care are obtained. Key appointments such as registered manager, clinical lead, registered nurse and care assistants still need to made.
Until the full staff complement is in place at all levels people may still be at risk of receiving poor care.

There was no thorough induction programme in place to ensure staff had the skills to care for people safely and were orientated into the ways of working in the home. Staff training was available in the home however a quarter of all staff had completed all the training expected of them.

People's mealtime experience was not pleasant. For some people it was unsafe and for others it did not take into account their needs and preferences. People were not complimentary about the food.

Concerns had been raised by staff and relatives about the cleanliness of the home. Some bedrooms were very clean and attractive. Others required deeper cleaning. There was dirt on top of beds. In the en-suite facilities some toilets and mirrors needed attention. There had been problems with the laundry equipment which had not been working.

Whilst we observed some caring interactions between staff and people living in the home some aspects of care and support needed to improve to promote people's dignity. People found staff to be kind but they were often rushed and "too busy" to spend time with them.

At this inspection the provider had failed to effectively monitor the quality of the service being provided to people and take action to improve it. This had resulted in the provider being unaware the issues we identified during the inspection. For example, the provider failed to be aware of the impact on the care people received because of the reduction in staffing. The provider had also failed to recognise the poor mealtime experience for people. The provider had failed to know people's views about the food.

The provider had quality assurance systems in place to monitor care and plan on-going improvements but this had not been effective. At the last inspection we identified some specific areas of practice in the service that needed to be improved. For example the orientation boards in Greenwood, poor food service and the experience of people receiving poor respite care. These had not been addressed and in some cases had deteriorated further.

The day after the inspection we received a detailed recovery plan from the regional manager. The regional manager had taken immediate action to improve the staffing levels and keep people safe. Action had also been taken by the local authority and clinical commissioning team to review people's care needs in detail and ensure they were being met.

A whole service safeguarding meeting was held immediately after the inspection. At the meeting it was confirmed that neither the Local Authority or the Clinical Commissioning Group were commissioning care at the home. Further meetings have been planned to monitor the progress of the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see some of the action we are taking at the back of the report, we are considering other action we are taking for the other breaches of Regulations.

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.

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.

There were insufficient staff to meet people's needs safely.

Risks to people's health and safety were not managed safely.

People received their medicines when they needed them from staff who were competent to do so however some aspects of medicine administration and recording required improvement

Is the service effective?

Inadequate

The service was not effective.

People were not supported to eat and drink safely. They did not always receive a nutritional and appetising diet.

Staff did not receive effective support, induction, supervision or training to ensure they were skilled and competent to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People received some caring interactions from staff but people's dignity was not always promoted.

Staff did not have the time to spend with people to listen to them and make sure make sure they mattered .

Is the service responsive?

Requires Improvement

The choices people were able to make about their daily lives were limited by the number of staff available.

People's records were personalised to each individual and contained information to assist staff to provide care in a manner

that respected their wishes. There was evidence the nurses planned care and up-dated records. People's records did not always show clearly what peoples needs were or how they had been addressed.

People receiving respite care in the home were not satisfied with the standard of service the home provided.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager, clinical lead or full registered nurse team in place in the home.

Systems to assess, monitor and improve the quality and safety of the service were ineffective.

Aspects of the service identified at the last inspection as requiring improvement had not been addressed.

Hendford Care Home with Nursing

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 19 April 2016 and was unannounced. It was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. At the last inspection on 3 August 2015 the service was rated as Requires Improvement. In the domains safe, effective, responsive and well led areas requiring improvement were identified.

A breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014: Need for Consent was identified. We received an action plan and found this had been addressed at this inspection.

At the time of this inspection 24 people lived in the home. During the inspection we met with all the people who lived at the home and eight members of staff. We met with the peripatetic manager and the provider's regional manager.

We looked at a sample of records relating to the running of the home and to the care of individuals. These included the care records of six people who lived at the home and four staff recruitment files. We also looked at records relating to the management and administration of people's medicines, health and safety and quality assurance.

Inadequate

Is the service safe?

Our findings

At the last inspection in August 2015 improvements were required to ensure the deployment of staff helped meet the needs of people. People and staff did not always feel there were sufficient staff around to meet people's needs in a relaxed and unhurried manner. People who had come to stay in the home for respite care felt they did not receive sufficient attention from staff who were busy supporting other people. Following the August 2015 inspection we received an action plan from the provider stating that the staff numbers would be increased.

At this inspection the number of people living in the home and the staff on duty had decreased. There were 24 people in the home. The number of staff required was determined by the provider's staffing model. The model sent to us did not take into consideration the lay out of the home over three floors. There was also no consideration of the staff required to meet people's social needs when they were confined to their bedrooms or required skilled support as a result of living with dementia.

In the afternoon of the inspection the staffing levels in the home were not safe. One member of staff did not arrive for their shift and this resulted in there being one nurse and three care staff on duty to care for twenty four people over three floors. The needs of people in the home varied from those who had complex nursing needs and remained in bed to people with dementia who were very active and needed constant support and supervision. There were also a small number of people receiving respite care. The impact of the staff shortage was that only one member of care staff was working on Greenwood. They were responsible for the total care of ten people with varying degrees of dementia. When the nurse went to Greenwood to give out medicines the member of staff was able to give personal care to one person. They said if the nurse had not arrived they would not have been able to leave the room and the person would not have had their needs addressed. They told us they were "often" on their own from five till eight pm and they did the best they could. The staff rotas we saw confirmed this level of staffing had occurred on at least one other occasion in April.

One person was in bed on Greenwood and had been given their evening tea in bed. They had spilt chocolate pudding all over the floor as they had not been able to manage to eat without assistance. Staff said if they needed assistance at any other time staff would be called from another floor. However this would leave that floor short of staff and people would need to wait till the staff member returned.

During the morning of the inspection people were not supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. The staffing allocation was one nurse supported by four care assistants. This was determined by the provider staffing model. People gave us examples of the ways in which this level of staffing had impacted on their care and safety. People said "I never saw any staff from 2-5:30 yesterday. Care is not taking place in here but I can see to myself." "Staff are not up here but I have a phone so I can phone them." "I fell yesterday. Staff told me I should have called for help. I managed to get myself up."

Staff told us they were not able to get people up in a timely manner. One member of staff told us at 12:30

"We still have one person to get up." The two care staff covered Silverbirch and Pineview where 14 people were receiving care. People needed assistance to go to the toilet during the morning and staff were often unable to continue delivering personal care to enable people could get up.

Staff told us they felt "very sad" they had to rush through the morning routine and were unable to offer people "the time and attention" they deserved. Some people appeared to need further help with oral hygiene which could impact on their health and well-being. People also required assistance with fluids and to change position on a regular basis. We saw some fluid and repositioning charts had not been fully completed. This made it difficult for nursing staff to determine whether care had been given and could affect decisions about people's needs. Many people did not leave their rooms so were also dependent on staff for social support and stimulation which was not provided on the day of the inspection. One person had had their nails painted but the varnish had nearly worn off giving them an uncared for appearance. Some hot drinks which had become cold were seen in people's rooms where staff had not been able to assist the person with them.

In the morning there were two care staff to provide support to people on Pineview and Silver Birch. The nurse on duty was providing support across the whole home. This number of staff was not sufficient to ensure people on the nursing floor received sufficient help to eat their lunch. People who were eating in their rooms were left with food in front of them but were unable to have the support they needed straight away.

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

Action was taken promptly following the inspection to increase the staff allocation during the day and at night. However time is needed to embed the new staff ratios and to ensure the staff numbers are managed effectively so that improvements to care are sustained. Key appointments such as a registered manager, clinical lead, registered nurse and care assistants still need to made. Until the full staff complement is in place at all levels people may still be at risk of receiving poor care.

The number of registered nurses employed in the home had reduced. There were now two nurses employed in the home on day duty and two on night duty. This meant some shifts were covered by agency staff who might not know the needs of people. Four weeks of rotas showed agency nurses covered the home for one or two long days each week.

An activity co-ordinator was employed six days a week but was not working on the day of the inspection. They were normally based in the Greenwood lounge area. This meant care staff on Greenwood also tried to provide people with social stimulation on this day. One member of staff was based in the lounge with a puzzle on the table. Three people sat at the table while other people sat in chairs around the room.

Some people who were able to express an opinion told us they felt safe at the home and with the staff who supported them but wished there were more staff. One person said "I do feel safe here but nobody asks if you are happy. They don't have time." Another person said "I do feel safe here. I stay in my room because of my oxygen. If I want to go about I put my oxygen pack in my walker. Staff keep leaving. It is so sad."

Care plans contained risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves and others. However one person was receiving assistance to eat and drink that was unsafe. Their care plan stated they needed to be fed with a teaspoon sitting in an upright position to minimise their risk of choking. We saw they were assisted to eat their tea using a dessert spoon. They were slumped in their bed. When asked, the agency staff was unaware of the guidelines or risks

associated with the support required to keep this person safe. They did not know the person needed to remain in a sitting position whilst being supported with food or the observations that needed to take place for 20 minutes following the meal. The person was slumped in their bed with food coming out to the sides of their mouth, clearly uncomfortable and unable to digest their food safely. After the inspector spoke they said they would find someone to help them move the person into the safe position.
This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

When we spoke with the peripatetic manager following the inspection they told us further action had taken place to minimise the risk of this person receiving unsafe care again. They had completed a diet notification detailing the person's needs and ensured all staff were aware of the person's needs.

Risks of abuse to people were minimised because the provider's recruitment processes made sure that all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and checking that prospective staff were safe to work with vulnerable adults.

Some staff had received training in how to recognise and report abuse. Further training had been organised for new staff. In the past year where allegations or concerns had been bought to the previous registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

People's medicines were administered by registered nurses. Medication audits indicated some improvements were required to the management and administration of medications. The peripatetic manager told us on-line medication training up-dates had been arranged and competency assessments would be undertaken following the training. The peripatetic manager had undertaken medication audits to confirm medication administration in the home was safe.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct.

Some people were prescribed medicines on an 'as required' basis for pain. At lunch time the nurse asked people if they needed any pain relief. They took time to ascertain whether the person needed anything if they were not able to answer verbally.

Concerns had been raised by staff and relatives about the cleanliness of the home. Some bedrooms were very clean and attractive. Others required deeper cleaning. There was dirt on top of beds. In the en-suite facilities some toilets and mirrors needed attention. There had been problems with the laundry equipment which had not been working. One relative told us "This is a super place, but the management don't seem to understand the importance of having a reliable washing machine. They are still waiting for it to be fixed. People need access to clean clothes." Some carpets were badly stained. There was a cleaning checklist in place in the home. The form had a space for the housekeeper to confirm cleaning had been satisfactory however no housekeeper was employed.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Concerns had been raised about the availability of infection control equipment such as gloves and aprons. There was an ample supply of incontinence products, gloves and paper towels although some rooms lacked a bin to put used towels in.

Inadequate

Is the service effective?

Our findings

At the last inspection in August 2015 improvements were needed in how people were supported at meal times. At this inspection people's mealtime experience was still not pleasant.

For some people it was unsafe and for others it did not take into consideration their needs and preferences. People were not making choices about their food as their menus had been completed the day before. People were not complimentary about the food. One person told us "I don't like it here anymore. I used to like it. Meals are always late and not always hot. We don't know what we are having. They do come with a menu but I forget." People also said "The food is horrible. It is burnt or cold. They don't know how to cook." "Food is generally ok but they can't cook. Roast ham is like pink felt. Awful. I wish I could go to the kitchen and tell them how to cook." We read a copy of the four week menu which included a vegetarian choice and a salad each day.

We observed the lunch being served on Silver birch and Greenwood. On Silver birch meals arrived ready plated up which meant people were not able to make choices about the amount or components of their meals. Salad had been put on a hot plate with lasagne which meant the salad was limp and unappetising. People did not eat the salad which meant they did not receive this nutritious part of the meal. The dessert arrived in a bowl with custard already poured over it and a dessert spoon already stuck into it. No alternative dessert was offered which meant people could not make a healthier choice of fruit or yoghurt if they preferred. Some people had diabetes and required a specific diet. There was no indication on the menu or amongst the food being served what dessert they should be offered.

At lunchtime three people sat in the Silver birch lounge. One person was able to eat independently and their lunch arrived promptly. However there were not enough staff available to assist people who needed help so the other two people waited some time to be assisted. One person was not able to cut their food and the top of the meal fell into their lap. Staff seemed unsure who was having soft diets. One member of staff said "Is X having soft? Has she had any breakfast?" They told one person "I am not sure what this is but I hope it tastes nice." Soft food was separated into three different components but without a menu or label therefore staff could only guess at the actual meal they were serving to people. Staff tried to support people but there were not enough of them to ensure people had a positive experience which respected their dignity and gave them hot food.

On Greenwood all the people sat at the table except one person who sat in a chair with a member of staff to assist them. There were no condiments on the tables and people drank from plastic mugs. At tea time we examined the food brought to people on the trolley. Soup had been brought to the unit in a jug and when we examined it there was a strong smell of burnt food. The soup had been given to people even though it was very evident that it had been burnt.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs

People were cared for by staff who were not being supported to ensure they had the skills and knowledge to meet people's needs.
There was no thorough induction programme in place to ensure staff had the skills to care for people safely and were orientated into the ways of working in the home. One new member of staff was on duty for the first time during the inspection. They were appropriately qualified and had previous experience. They told us they had undertaken "plenty of dementia care training." The peripatetic manager told us a new member of staff should follow the provider's induction policy. This included watching videos and receiving in-house training. A new member of staff should also undertake a number of shadow shifts before assuming their full responsibilities as a member of care staff. In the morning we met a new member of staff working as the second member of staff on Greenwood. This meant the induction policy had not been followed which could have put the new member of staff at risk of delivering inappropriate care and support and people receiving unsafe and inappropriate care.

The training grid maintained by the provider indicated 23% of staff had completed all the training expected of them. Further training dates had been planned. One operational manager report commented on the poor attendance of staff at training.

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

There was a qualified nurse on duty to make sure people's clinical needs were monitored and met. Since the last inspection the number of qualified nurses in the home had reduced and some shifts were covered by agency staff. There was no clinical lead in the home to lead the nursing team and monitor the nursing needs of people on a regular basis.

People were at risk of not receiving effective care. In care plans there was some evidence people's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. However one nurse had not been trained in the use of the MUST system. This is a system that assesses people's risk of malnutrition and guides staff on the appropriate action to be taken. A recent review by the District Nurse commented on one person's care plan considerable loss of weight. Despite the recorded loss of weight the MUST/BMI had not been calculated since December 2015. Nearly a month after the review, action had not been taken to calculate the risk of malnutrition or to put in place an appropriate care plan. Another person was receiving assistance to eat that was a major risk to their safety as it did not comply with the guidance in their care plan .

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

At the last inspection in August 15 the provider was in breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. At this inspection we found improvement had been made.

Many people who lived in the home were able to make decisions about what care or treatment they received. Some people in the Greenwood unit had been deemed not to have the capacity to make decisions about some aspects of daily living.

People were always asked for their consent before staff assisted them with any tasks. One member of staff said to people "Is it alright if I help you now?" and each time waited for a response. In Greenwood people were given time to move or adjust to the information they were being given.

Senior staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. There were records that confirmed the previous manager and staff had participated fully in procedures and systems relating to MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Since the last inspection 23 DoLs applications had been made to the local authority. We saw MCA assessments and Best Interest check lists in people's records where applicable.

Greenwood had been purpose built to support people living with dementia however some practices related to the environment needed to be improved to reflect best practice. At the last inspection there was no support in the unit to orientate people of the day, month or year. For example the day of the week was not displayed. This had still not been addressed. French doors from bedrooms into the secure paved garden were blocked by large chairs with cushions drying in the fresh air. This would have made it difficult for people to walk about freely. The doors were not closed by the late afternoon meaning the bedrooms would have been chilly when people began to go to bed. Outside one person's bedroom leading out to the enclosed garden there were a large number of cigarette ends which looked disrespectful. A garden area had been identified for people able to access a non-secure outdoor space. This had become overgrown and unattractive.

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

The home usually arranged for people to see health care professionals according to their individual needs although we did find one person's health needs had not been addressed. On the day of the inspection a chiropodist was in the home. They told us they visited regularly and found staff helpful. People were supported by regular visits to the home by GP's. A relative said when their family member had become ill the home had quickly identified the problem. The doctor had been called and they were taken to hospital. The family had been kept informed. Records showed people were either visited by specialist healthcare staff or attended external clinics. For example the Parkinson's Disease specialist nurse visited one person to check their medication regime and offer support to the person and staff.

One person had been assessed as needing one to one support because of their complex needs. The care staff providing this care was knowledgeable and attentive to the person's needs. Comprehensive records showed regular support was provided.

Requires Improvement

Is the service caring?

Our findings

Whilst we observed some caring interactions between staff and people living in the home some areas needed to improve to promote respect and people's dignity.

The service of meals on Greenwood was not respectful. Food arrived on a trolley. Dirty crockery and cutlery were put back amongst the food. A person was offered a second cup of tea. The tea was poured into the cup without using the saucer. A person was given a large spoon to eat their yoghurt. There was no ready supply of napkins to assist people with wiping their mouths.

There were examples of care that did not always support people's dignity. One person was taken from the lounge in Greenwood in a wheelchair without any footplates. This meant they had to hold their feet up to avoid hurting them. People's possessions were not always respected. Their clothes were crammed into drawers and wardrobes. People's clothes were not well laundered and presented. People wore crumpled cardigans and trousers. There were hairbrushes full of hair, dry, hard toothbrushes and in one en-suite room a collection of bits of old soap. At the lunch table on Greenwood one person clearly needed assistance to access a tissue. One member of staff sat next to them oblivious to this and the inspector asked another member of staff to assist the person.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Some people said they were supported by kind and caring staff. "Staff always treat me kindly." "Everyone is kind." Another person said "Certain staff will put themselves out often surprisingly.". On Greenwood one person was heard to call for help. The carer arrived promptly and said "I have got you. I have got you now." The person smiled and gained confidence in their mobility.

Whilst we saw some positive interactions between people and staff some people did not feel cared for. One person told us, "No, nobody asks how I am feeling or if I am happy. They don't have the time. They help me up about seven. I fell out of bed the other night. I rang the bell and they came." Another person said, "Staff keep leaving. I don't know why we see different staff all the time." Staff told us the staffing levels made it hard to find time to "sit and have a chat."

People's privacy was respected and all personal care was provided in private. A notice on the door told others not to enter whilst care was being given. In the morning on Greenwood a person needed assistance with personal care and the care staff responded promptly and discreetly.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. We spoke with two visitors. One relative told us they were very happy with the care their family member received. They said they were kept informed of any changes in the person's condition. Another relative told us they were very satisfied with the care. One healthcare professional told us they found staff to be caring and ready to respond to any

requests they made.

On Pine View and Silver Birch people spent their time mostly in their rooms. People on Greenwood were able to move freely about the unit. There was an enclosed garden that could be accessed from some people's rooms. However with only one member of staff available this limited people's choice as no support was available.

There was some evidence people's care plans had been up-dated with them but also examples where their needs had changed and this had not been recorded. One care plan said the person was able to eat their meals independently. We saw this was not so during the inspection.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

Requires Improvement

Is the service responsive?

Our findings

The three units in the home were intended to meet people's differing needs and provide care that was responsive to their needs and personalised to their wishes and preferences. On Silver birch people had mainly nursing needs. Greenwood aimed to provide a service for people living with dementia. However the support and care available was limited by the shortage of staff and the inability of the home to provide specialised care.

At the last inspection in August 2015 concerns were raised about the experience of people who came to stay at the home for respite care on Pine view. People had not felt the service was meeting their preferences. They did not feel they had received sufficient attention. This had not improved.

People having respite care at this inspection said "It used to be good here but not anymore. I walk up and down the corridor as there is nothing to do. I am going home today. Thank God." Another person said "I just stay in my room. If I press my call button they take a long time to come. We don't see staff here often. They tell us they cannot come because they are supporting other people. We do have a sheet that tells us what activities are going on. I don't go." Staff supporting people on Pine view were also providing care to people on Silver Birch. Some of whom had been assessed as needing two people to care for them.

Activities were organised and mainly delivered in the Greenwood lounge. There was a hand written activities sheet for April 2015 that included a variety games, some music and entertainments. People we spoke with in other areas of the home told us they did not take part in the activities very often. One person said "I don't do activities but I enjoy getting my hair done weekly." Other people were helped to go to Greenwood if there was an activity they were interested in. People were able to make choices about some aspects of their day to day lives but this was always governed by the availability of staff. One person said "The staff are kind. They say would you like to stay in bed a bit longer. I think it makes it easier for them."

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. Staff did not read the main care plans but there were summaries of people's needs in files in their bedrooms. One relative talked to us about how the decision to move their family member to the home had come about. They said "X needs to be safe and I feel they are safe here." Another person talked to us about the decision to move to the home. They said "I chose this room with my daughter. We speak every day. I love all my personal things around me."

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. There was evidence the nurses planned care and up-dated records. One care plan informed us the person was at risk of pressure damage, they had a profile bed and moved about the home in a wheelchair. They liked company and went to Greenwood to participate in the activities. They had received visits and treatment from their GP. From other plans we were able to gain a picture of the needs of people and the care they received. However it was difficult to find different pieces of information and understand what had happened to people.

A main care plan was augmented by a red folder kept in each person's room. These contained summaries of the care people needed and contained the charts recording people's food intake and change of position. Some charts were not fully completed. A review undertaken by a healthcare professional on 31 March 2016 raised concerns about the care provided to one person. The review identified concerns about the person getting up in a timely manner. The person was at high risk of pressure damage but the review noted recording of changes of position had been poor.

There were some omissions in care plans. For example there was no care plan to support one person specifically with their Parkinson's disease. Another person required more help than was identified in their care plan.

People were supported to maintain contact with friends and family. One person said "My family come in when they want to." One person was going out to lunch with their daughter and was able to discuss where they would go and what they might like to eat.

Each person received a copy of the complaints policy when they moved into the home. People told us they would usually ask their relatives to raise any issues for them. The complaints folder showed when complaints were raised they were investigated and a response was made to the person concerned. Action had been taken to address complaints by the previous registered manager.

Inadequate

Is the service well-led?

Our findings

At the inspection in August 2015, it was the first inspection since the provider Caspia Care Ltd had taken over the service. We found the management structure and systems to review the quality of care were not embedded to demonstrate sustainability.

At this inspection we found the provider had failed to effectively monitor the quality of the service being provided to people. This had resulted in the provider being unaware of the issues we identified during the inspection. For example, the provider failed to be aware of the impact on the care people received because of the reduction in staffing. The provider had also failed to recognise the poor mealtime experience for people. They had also failed to seek people's views about the food. Therefore the provider's quality assurance systems were not effective in identifying poor practices or where improvements were needed. At the last inspection we had identified some specific areas of practice in the service that needed to be improved. For example the orientation boards in Greenwood, poor food service and the experience of people receiving poor respite care. These had not been addressed and in some cases had deteriorated further.

The registered manager had left the service at the end of February 2016. There was a peripatetic manager who had been working in the home for five weeks. They were supported by the regional manager. The peripatetic manager was aware there were aspects of the service to be addressed. Some actions had started to be taken to improve the recording of care. An allocation sheet had been introduced to ensure essential tasks had been completed on each shift. Some recording documents had been up-dated and improved. However they had not identified the poor practices we had during the inspection. The provider was actively trying to recruit a new registered manager.

There was a staffing structure in the home designed to provide clear lines of accountability and responsibility. There was a registered nurse on duty at all times in the home. At the time of the inspection 15 people had been assessed as needing nursing care. There were 24 people living in the home. The nurse was responsible for all people across the three units of the home. This meant they were spending time dispensing medications and caring for people who had not been assessed as needing nursing care and were not available to people who had been assessed as needing their care. There was a named shift leader who was counted as one of the care assistants. On the day of the inspection this person was providing care to people on the Greenwood unit for twelve hours. This meant they had no opportunity to undertake any supervisory duties in other parts of the home or to support the nurse.

There were few records of formal staff supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff told us they had not received supervisions recently. This meant that concerns about staff performance were not being addressed in a formal way.

The lack of effective governance is a breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Good Governance.

The day after the inspection we received a detailed recovery plan from the regional manager. The regional manager had taken immediate action to improve the staffing levels and keep people safe. Action had also been taken by the local authority and clinical commissioning team to review people's care needs in detail and ensure they were being met.

Recruitment for additional staff had been prioritised and the home received the immediate support of an additional peripatetic manager. We contacted the peripatetic manager to confirm additional staff were in place and they were.

The plan also stated all senior staff were to receive medication training to enable them to deliver medication to residential people. This would free up the nurse to concentrate on people assessed as needing nursing care. Care delivery and meal time service was to be monitored to ensure that it is managed in a dignified and safe manner. Staff were to be supported to ensure they had read care plans and understood the care to be provided. Staff were to receive more training in caring for people with dementia. Activities were to be further developed.

A whole service safeguarding meeting was held immediately after the inspection. At the meeting it was confirmed that neither the Local Authority nor the Clinical Commissioning Group were commissioning care at the home.

The regional manager attended the home regularly and completed a comprehensive quality monitoring report. They had visited the home twice in January, four times in February and five times in March. The reports confirmed there had been infection control audits, health and safety audits and medication audits. The review of a "client per day" system aimed at looking in depth at one person each day and reviewing their documentation and checking they were satisfied with the care they were receiving. Despite this monitoring, the issues identified during the inspection had not been picked up during these visits by the regional manager.

Numbers of reported accidents, infections, pressure damage and complaints had remained fairly constant and low across the three months. Observations of staff interactions in the home had been positive. Changes to the staffing model were noted but not described.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Some interactions between staff and people living in the home needed to improve to promote people's dignity. 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because care and treatment was not provided in a safe way. Staff did not follow good practice guidance and adopt control measures to ensure the risk to people was as low as possible. 12(1) 12(2)b

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not receive a variety of nutritious, appetising food. When people lacked capacity they did not receive sufficient prompts, encouragement and help to eat as appropriate. 14(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Some parts of the premises were not clean or

suitable for the purpose for which they were being used.
15(1)(a) and 15(1)(c)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems and processes which assessed, monitored and improved the quality and safety of the experience of service users living in the home. Regulation 17(2)(a)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's needs safely. Staff had insufficient time to provide adequate care and support to people with nursing needs and those living with a dementia. 18(1) The provider did not ensure staff received appropriate support, training, professional, development, supervision and appraisals is necessary to enable them to carry out the duties they are employed to perform. 18(2)(a)

The enforcement action we took:

We issued a warning notice.