Woodland Healthcare Limited

Mr 'C's

Inspection report

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17 November 2016
21 November 2016

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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

Mr 'C's is a nursing home in the centre of Torquay. Mr 'C's is a care home in the centre of Torquay. Mr 'C's is a care home in the centre of Torquay. It is registered to provide accommodation and personal care to up to 40 people who may have needs related to dementia. The home also provides nursing care. There is a nurse on duty during the day, and at night one nurse covers three homes owned by this provider.

This inspection took place on 16, 17 and 21 November 2016 and was unannounced. During the first two days of the inspection there were 19 people living at the home and on the third day of the inspection there were 18 people living at the home. The home is spread over five floors with the dining room, kitchen and lounges on the ground floor and people's bedrooms on the first to fourth floors. People with the highest level of nursing care needs had bedrooms on the first floor, where the nurse's base was situated. People who were more independent, with residential care needs were furthest away, on the fourth floor. At the time of the inspection, there were eight people requiring nursing care and eleven people requiring residential care living at the service. Twelve people needed the help of two care staff to assist with their mobility. Two people were living with dementia type illnesses.

The service was first inspected in August 2014, when we identified the provider was not meeting the regulations in respect of records. We carried out a ratings inspection in August 2015 when the home was rated as Requires Improvement. The provider was not meeting the regulations in respect of ensuring people received safe care and treatment, staffing levels and record keeping. The provider sent us an action plan that confirmed improvements would be completed by December 2015. At this inspection we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. We also identified new areas of concern.

We have found people were not always receiving a safe, effective, caring, responsive or well-led service.

The home had a registered manager. 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. The registered manager was responsible for two nursing homes owned by the company and had a quality monitoring function for a third home, one day per week. This meant they only spent two days a week at Mr 'C's, sometimes split into half days. The lack of a consistent manager presence had impacted on the safety and quality of care and led to people and their relatives losing confidence in the overall management approach.

The layout of the building presented challenges for staffing. There were not always enough staff on duty at all times to ensure people received the care, support and observation they needed. At night there were two care staff on duty to cover the home. A registered nurse covered Mr 'C's and two other nursing homes in the group overnight. They were not always present at Mr 'C's. Although the registered manager told us they had assessed staffing levels, the consistency of concerns raised indicated people did not always receive

assistance at the times they needed it.

Staffing levels meant staff were not always able to provide care in a way that ensured people's dignity was protected. For example, on the second day of our inspection when we arrived we found one person downstairs walking by the reception area who was naked from the waist down. There were no care staff on the ground floor at this time.

Complaints about some aspects of care were repeatedly raised by people living at the service and their relatives. These included the varying availability of hot water in parts of the home and call bells not being answered in a timely way. Although the service had a system in place for responding to complaints, we found the service had not investigated these concerns sufficiently to fully understand the issues or put them right. For example, we found the call bell system had not been working reliably since the home opened in May 2014. There was no hot water on the second day of our inspection on one floor of the home. Both these issues were resolved by the registered manager. However, they had not been resolved when people had complained. Some people were unhappy with the way their complaints had been responded to they had asked the local care Trust for support.

Risk assessments and care plans were in place for each person. Although risks to people had been identified, the steps to be taken to deals with those risks were not always clear. Care plans did not always give enough detail to staff to be able to manage those risks. Whilst there was a lot of information available within care plans, the important information could be difficult to find. Sometimes care plans used highly medicalised language which was unlikely to be accessible for people, their relatives or care staff and could restrict involvement in planning of care.

Some areas of risk were not identified, assessed or managed. For example, bed rails were widely in use in the home to prevent people falling from bed. There were no risk assessments in place regarding their use. Some bed rails did not have protective soft coverings to reduce the risk of entrapment or injury. There were no specific risk assessments in place regarding risks for people who could not call for help. One person's care plan said they should be checked every hour, but there was no system for ensuring that they had been checked on regularly, and the rationale for these decisions had not been recorded, as they should be. Where one person was at risk of pressure sores, there were no records to evidence they were repositioned in line with their care plan.

Body maps were used to show where people had broken or sore areas of skin. These were cluttered and unclear and this made it difficult to track the progress of people's wounds. One person's body map said they had a grade two pressure sore, but there was no evidence of any guidance for staff regarding treatment of this. Lack of clear recording increased the risk that care may not be provided in a safe way.

Management of topical creams was unsafe. Nurses were signing to say these had been applied. However, nurses were assuming they had been applied by someone else. This placed people at risk of creams not being applied correctly and skin becoming sore and breaking down, or medical conditions not being treated effectively. The registered manager took actions to address this.

The environment was not suitably adapted to meet the needs of some people who were living with dementia. For example, signage was not in place to help people orientate themselves and patterns on the floor coverings on the ground floor were confusing and unsuitable. We have made a recommendation in relation to this to the provider.

Although staff had received training in relation to the Mental Capacity Act (MCA), this learning was not being

applied. Capacity assessments were not decision specific or individualised for each person. Capacity assessments and best interest's decisions were not completed where they should have been. For example, in relation to the use of a lap safety belt or bed rails.
Applications for Deprivation of Liberty Safeguards (DoLS) had not been made for everyone who legally required this safeguard. This meant people's human rights were not fully protected.

The premises were not free from offensive odours. Odours of urine were noted at different places and different points of the inspection, in some bedrooms and communal areas. We have made a recommendation in relation to this to the provider. Where one person was living with dementia and had difficulty getting to the toilet in time, there was no care plan in relation to managing their continence.

At the last inspection we found that there was a low level of social activity in the home and concerns about people being socially isolated. At this inspection we found improvement had been made in this area. A new activities organiser had been appointed and was working individually with people. There were more organised activities available for those who could take part. However, some people's choices were restricted because they could not leave their bedrooms.

Staff understood the principle that people should be supported to make their own choices and decisions about their care wherever possible. We heard staff asked people for consent before delivering care and offered people choice to support decision making.

People were supported to maintain their health through good nutrition. People told us they liked the food and were able to make choices about what they had to eat. One person said "The food is alright, no complaints there". Another said "The food is good and there's a choice." Pictures of different meals were available to assist those who had communication difficulties. Every morning the chef spoke with people individually about their food preferences for the day. Some people had specific dietary needs. The chef had been trained to cater for those needs.

People spoke highly of the care they received from staff. Comments included, "The staff have always been very good to me". Asked if the staff seemed caring, one person said, "Yes, they do. Very kind. I just don't think there is enough of them. They laugh, joke and are very kind." Another person said staff were always "Smiley and happy" and there was a good atmosphere in the home. We observed staff caring for people during the inspection. Staff addressed people with their preferred name. We saw that staff were cheerful and positive when talking with people, and treated them with respect. People responded to this by smiling and engaging with staff in a friendly, affectionate way.

Staff told us they always put people first and treated people in the way they would wish their family members to be treated. Relatives were involved in their family member's care, where appropriate. However, staff were working in a culture of acceptance where it had become acceptable that problems could not be fixed. This resulted in people at times not having access to hot water, items of clothing being lost and the existence of a general disclaimer note saying the home would not accept responsibility for lost belongings.

Routines within the home were flexible. People told us they could get up and go to bed when they wished and eat their meals where they wished. People said if they changed their mind about what time they wanted to go to bed, or what they wanted to eat this was never a problem with staff.

The provider had a range of quality monitoring arrangements in place to monitor care and plan ongoing improvements. This included audits, surveys and regular health and safety checks. However, systems in place had not identified shortfalls found at this inspection or ensured that sufficient action was taken after

our previous inspections. We had some concerns regarding fire management and we have referred that to the fire authority.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, and made two recommendations. The actions we have taken are detailed at the end of this report.

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.

People were placed at potential risk of harm because risks were not always identified, assessed or managed appropriately.

People did not always receive care when they needed it because staff were not deployed in sufficient numbers to meet their care and treatment needs.

People could not be assured they would receive assistance from staff when they needed it because the call bell system did not work reliably.

Recruitment procedures were not robust which meant people may not be protected from the risks relating to the recruitment of unsuitable staff.

People could not be assured they would receive their medicinal creams as prescribed because systems were not in place. Other medicines were well managed.

People were protected from the risk of abuse through the provision of safeguarding policies, procedures and staff training.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not fully protected because the Mental Capacity Act was not applied correctly and applications for Deprivation of Liberty Safeguards were not being made in a timely way.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported to have access to health professionals including GP's, district nurses and physiotherapists to help them have their health needs met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were doing their best to be caring. However the context in which they were working compromised this.

Staff were not able to provide care in a way that ensured people's dignity at all times.

People were encouraged and supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always responsive to people's changing needs.

People's complaints were not always investigated thoroughly or fully addressed. People were not always satisfied with the responses they received to their complaints.

People were supported to engage in activities of their choice.

Is the service well-led?

Inadequate

The service was not well led.

People did not benefit from a service where the registered manager was consistently available, due to their responsibilities in other services.

The service had monitoring systems in place but these did not operate effectively to monitor quality or drive improvement in relation to people's care or the environment.

People were not always protected from unsafe care because accurate and
up-to-date records were not maintained.

There were problems associated with this building that were difficult to fix and this impacted on people.

Mr 'C's

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 was 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 visit took place on 16, 17 and 21 November 2016 and was unannounced. The team included one adult social care inspector, a specialist advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This was a form that asked the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to ask for their feedback about this service.

On the first and second day of our visit, 19 people were living at the service. On the third day of the inspection, 18 people were living there. We used a range of different methods to help us understand people's experience. We met with everyone living in the service and spoke in more detail with 10 people, as well as four relatives and three visitors. We spoke with the registered manager, two members of staff who described themselves as deputy managers, two registered nurses, and seven staff. We also spoke with six visiting health professionals and sought feedback from the local Care Trust commissioning team and safeguarding team. We spent a short period of time carrying out a Short Observation Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

We looked at seven people's care records, medication records, staff files, audits, policies and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found people were not always receiving safe care and treatment. Poor monitoring and record keeping placed people at risk of harm. Staff were not deployed in a way that ensured people always received care when they needed it. Following the inspection the provider sent us an action plan to show us how they intended to make the improvements to ensure people's safety. At this inspection we found the provider had not taken sufficient action to make the required improvements.

There was a system of recording that included risk assessments and care plans. These were completed by registered nurses and reviewed monthly. However documentation about people care needs was fragmented and difficult to follow. Key areas of risk and the instructions or guidance about care that staff needed to manage this risk, was not presented in a logical pathway. For example, areas of risk such as choking, falls or pressure care were identified individually within risk assessments, but did not lead to a clearly defined plan of care in these areas. Information was spread through a range of different sections under headings such as 'Safety plan' and 'Communicating with me', 'How I eliminate' and 'How I uphold my dignity and avoid discomfort'. This meant staff did not have clear care plans and pathways about distinct areas of care, such as pressure area care, continence care, or managing falls risks. There was a possible risk that people would not receive safe care as there was a lack of clear instructions for staff about how to mitigate risks.

Risk assessments and management plans were not sufficiently well developed to mitigate or manage risk. For example, we found some basic risk assessments had been carried out in relation to the risk of people developing pressure ulcers, of people falling, choking and risks in relation to assisting people to move. The registered manager told us that where potential areas of risk were identified, more detailed risk assessments would be completed. However, we found this was not always the case and risks were not being managed safely. One person who was at medium risk of falls did not have an in depth falls risk assessment or management plan. Incident records showed they had been found on the floor on two days in November 2016, although they had not suffered injury.

After the inspection we clarified with the acting manager the number of people who were unable to use call bells due to either physical restrictions or cognitive impairment, such as dementia. We were told seven people were unable to use call bells to seek assistance from staff. There were no assessments in relation to the risks associated with not being able to call for help. One person had a care plan which noted their inability to call for help. The care plan stated staff should "check on me often" and "staff check on my safety every hour". Another person regularly slipped out of their chair. Their care plan stated that the person needed to have hourly checks. However, there was no evidence these checks had taken place. When we asked staff about this, they said they checked people whenever they passed bedrooms, provided care, or when food or drink was served. This meant the nurse in charge could not check that appropriate checks were being carried out as per the care plan, to maintain these people's safety.

At the last inspection we found the way nurses and care staff were managing one person's diabetes was not safe. At this inspection we found records designed to give instructions on how to manage the risks to one person, from diabetes, were incomplete. There was no individualised record to inform staff of what was

considered a safe blood sugar level range for this person, as there should be. There was a general instruction sheet for staff to help them recognise the signs of a person's blood sugar becoming too high or too low. However, there were no indicators of what safe limits were for this person.

Bed rails were widely in use to protect people from falling from bed. However we saw no evidence of full risk assessments being in place regarding their use. Relatives of one person had raised a complaint about an incident when they found their relative in an unsafe situation with their legs hanging over the bedrails. They had received assurance from the registered manager that additional actions and checks would be completed to ensure this did not happen again. However, we saw there was no risk assessment in place for this person regarding risks associated with bed rails. There was no evidence in the care plan review or care plan of any additional actions or checks to reduce this risk. Staff confirmed no additional checks were being made.

Some bed rails did not have protective bumpers in place. These are soft padded coverings that reduce the risk of injury and entrapment within the bed. Lack of such covering, and the absence of this being risk assessed, placed people at risk of injuring their limbs in the bedrails.

One person's care plan said they needed to have their fluid intake restricted. Their care plan said they should only have one litre of fluid a day and this should be split into eight drinks of 125mls over the day. We observed this person had a very large jug of juice in their room as well as cups of tea, which they were able to help themselves to. This alone would take them over their recommended daily intake. There was no system in place to record or accurately monitor the fluid intake for this person. We spoke with the registered manager who said this person chose to ignore the guidance regarding their fluid intake and had mental capacity to make this decision. There was no documented evidence that the risks relating to this person ignoring medical advice had been discussed with the person in a way they could understand. There was no evidence of the risks of over consumption of fluids had been assessed or managed.

Some care plans were confusing or contradictory. One person was identified as being at high risk of developing pressure sores. Their risk assessment said two hourly positional changes were needed. The plan said "I have no pressure ulcers. I sleep on a profiling bed with an airflow mattress, the pressure of which is in ratio to my weight". There was no guidance for staff in the care plan regarding positional changes and staff confirmed these were not being completed. When we asked the registered manager about this they said the position changes were not needed.

Another person had a body map stating they had a grade two pressure sore. Having a grade two sore would indicate this is a damaged area of skin requiring treatment. However, there was no evidence in the person's records of any guidance for staff regarding care of this wound. The lack of recorded guidance for staff increased the risk that care may not be provided or provided in a safe way.

Body maps were cluttered and unclear. The maps were used to record several different wounds. Dates were not always recorded to show when the wound had been assessed. This meant it was difficult to track the progress of the wounds. Where people had wounds, there was no guidance in the care plan on how to manage the care and treatment of these.

We found the premises and equipment at the home were not being maintained in a way that ensured people were safe or fit to use for their intended purpose. We tested the call bell system and found it did not work effectively throughout the home. Only one person's call for assistance could be displayed at any one time. When an additional person rang for help, the details of the first call were lost from the display panel. This meant staff would not respond to the earlier call, as the details had disappeared from the display panel.

People were at risk because they could not reliably call for assistance and they may be left in unsafe situations. We discussed this with the registered manager who called engineers to the home to test the system the same day. We found evidence which showed the system had not been working properly since May 2014 when the provider opened the home. After the inspection we were informed that this fault affected three out of the five display panels in the home.

Concerns had been raised about the availability of hot water within the home in two complaints prior to our inspection. On the second day of our inspection we found there was no hot water available on the third floor of the home. This affected seven people who were living on this floor at the time. One person had urinary incontinence and personal hygiene was particularly important for them. One person told us they had not been able to have a hot shower for a long time.

The registered manager took action to call a plumber who diagnosed a fault with one boiler. The registered manager confirmed hot water was working effectively throughout the home before the end of the inspection.

We found the management of topical creams was unsafe. Some of these were prescribed to treat medical conditions and others for skin protection and to provide moisture. Many creams were prescribed 'give as directed'. There was no guidance for staff on where, when and how to apply creams. There was no signature sheet for care staff to sign to evidence that cream had been applied. Registered nurses were signing on the medication record that creams had been applied, but they had no means of assuring themselves that this had happened. Poor management of risks to people's skin placed them at risk of skin breakdown. We spoke with the registered manager about this and saw on the following day of inspection that action had been taken. Body maps were in place showing where creams should be applied and a recording system had been introduced for care staff.

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

The provider had not ensured there were sufficient staff on duty at all times. Most people and relatives told us they frequently had to wait for staff to attend to them. We found one person waiting in their nightwear in the corridor outside a bathroom at 11.00 am in the morning on the second day of our inspection. They told us they were waiting for staff to assist them to have a shower. People's comments included "The call bell doesn't work, very rarely have I had any help. We have just given up, don't bother anymore". Another person said "One expects somebody to answer a call; it's a bit worrying [that call bells are not answered]. It's not their fault, they [staff] respond when they can" and "You have to wait, mainly." One person told us that delays in responding were difficult for them as they needed help to get to the toilet and might have an 'accident'.

One visitor said "I have found [name of person] in a soaking bed; the call bell is not answered sometimes for a good half hour". Other comments from visitors included, "There is just not enough staff for the number of dependent people here" and, "I don't think they have enough staff. Another visitor said they had to search around the building to find staff to help after their relative had been incontinent of urine in the dining room area. They said that once they had found a staff member to help their relative, they had asked for a mop and cleaned up themselves, as there was no one available to help. Another visitor told us they had waited for between 30 and 45 minutes on a recent occasion for their relative to be washed and dressed and ready to go out, due to staff shortages. They expressed frustration as they had prearranged the time and paid for a private carer to assist with this.

Health care professionals we spoke with said they sometimes had to wait for staff to be available to assist them or to feedback to. One visiting healthcare professional said "Staffing can be a bit on the low side". Another visiting healthcare professional expressed concern about the layout of the home and the ability of staff to respond to people in a timely way. The provider advised that all health care professionals were encouraged to inform the home prior to attending to ensure staff are available to support the Home. If healthcare professionals attend without prior notice the provider accepts that there may be delays in supporting them as the priority is to meet the care needs of people.

Staff told us the size of the home was a challenge to them in getting around to people in a timely way. They said they had tried different ways of organising staff to try to overcome this, but it remained difficult. Some staff told us they were "stretched" at times, but noted things were better at the moment as there were low occupancy levels at the time of the inspection.

We asked the registered manager about people's current care needs and staffing levels on the first day of the inspection. They said there were 19 people living at the home. Eight of these people had nursing care needs. 12 people needed the help of two care staff to assist with their mobility (for example, if they needed to use a hoist to transfer between bed and wheelchair). Four people needed assistance with eating.

Staffing levels at the time of the inspection were a registered nurse and four care staff between 8 am and 2pm and three care staff between 2pm and 8pm. From Monday to Friday an additional staff member helped between 8pm and 10 pm. The registered manager was present for part of the week as they had other responsibilities in relation to two other homes in the group. There were a range of ancillary staff including two housekeepers, cleaners, and a chef and maintenance worker.

On the 17 November 2016, we arrived at 7.25am and were unable to gain access to the home for ten minutes, despite repeatedly ringing the intercom for both the nurse's station and reception. We were eventually let in by someone who lived at the home. We found a member of staff in the kitchen, who went to find a member of care staff. We found there was only one member of care staff, no nurse was present. The other member of care staff had gone home sick at 7.00am.

During the night time there were usually two care staff on duty. A registered nurse, referred to as the 'Peri' (Peripatetic) nurse, was available if needed for any clinical matters. The peripatetic nurse was not at Mr C's all the time as they covered two other nursing homes in the Woodland Healthcare group in the local area. The peripatetic nurse was backed up by a second registered nurse who was on call and could come to any of the services if there was an emergency or additional support was required. This system had not been effective on the morning of 17 November 2016. The peripatetic nurse went off sick at 5 am. The backup nurse then had to go to another home, leaving Mr C's with only 1 member of care staff for a period of approximately an hour.

The registered manager told us the layout of the building was a constant challenge. The building was spread over five floors and it took time for staff to reach people. The registered manager told us they used a dependency tool to calculate the number of staff needed to meet people's care needs. This was based on consideration of people's needs and peak activity times within the home. A staffing calculation tool was used to review staffing levels each month. This was a standard form used within the organisation. It did not factor in the specific challenges the layout and building size presented at Mr 'C's. In addition, it had not taken into account the consistency of concerns people had reported about staffing.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us in their Provider Information Return that the service was safe as they had a thorough employment process. We found the provider did not always operate robust recruitment or disciplinary processes. We checked five staff files. We found one member of staff had a past police caution. There was no evidence of any discussion about this or risk assessment to judge if this may pose a risk to people. Records in relation to three members of staff showed they had started working before their police check was received. We saw from records that another member of staff had a performance review in June 2016 and was given six weeks to improve their practice. There was no evidence this had been followed up. This meant people may not be protected from the risks relating to the recruitment and performance management of staff.

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

Although the premises appeared clean, odours of urine were noted at different places and at different times during the inspection. This included three bedrooms that were occupied and some bedrooms that were empty. The registered manager said this was due to one person having difficulty in managing continence issues and also, because one housekeeper had been off for the past few days with sickness. The registered manager had arranged for a cleaner from one of the other homes in the group to provide support with housekeeping duties. However, one family said their relative's room and their relative, frequently smelt of urine.

We recommend the provider reviews their homes odour management policy and practice to ensure the home is free of offensive odours.

Medicines were stored safely and securely. People had locked storage in their bedrooms for their prescribed medicines. The registered nurse administered people's medicines in an unhurried way and explained the purpose of each tablet. Medication administration records (MAR) were clearly signed with no gaps in the recordings, which indicated people received their medicines as prescribed. Where medicines were prescribed with a varying dose, such as warfarin, this was managed safely. For those people who were unable to express their needs, staff used a pain assessment tool to identify if people were in pain by their facial expressions.

People said they felt safe and secure at the home. People were protected from the risk of abuse as staff had received training in safeguarding people. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns. Staff were also aware of whistle-blowing procedures, whereby they could report any concerns to external agencies such as the CQC 'in good faith' without repercussions.

The provider had a policy of not managing monies on behalf of people who lived in the home, which they told us reduced the risk of financial abuse. Everyone had a lockable drawer in their bedroom where money could be kept if they wished. Where people were living with dementia, arrangements were in place for appointees to support them with managing their finances.

There were arrangements in place to deal with foreseeable emergencies. For example, a fire box was stored by the front door. This contained blankets, torches, water, and contact numbers and an emergency evacuation plan. The emergency evacuation plan listed the people who lived in the home, the number of staff required to support them to evacuate and the zones of the building they would be moved to in an emergency situation. The registered manager had arrangements with other local home owners for people to

be moved to alternative accommodation in the event of an emergency.

Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. We had some concerns regarding fire management in relation to staffing levels at night which we have referred to the fire authority for their consideration.

Staff had access to hand washing facilities and used gloves and aprons appropriately to reduce the risk of infection control. Domestic chemical products were stored securely. Housekeeping staff had suitable cleaning materials and equipment available to use. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Requires Improvement

Is the service effective?

Our findings

The dining area and TV lounge were impersonal and did not have a homely feel. One person said "It's not home-like here". The TV lounge area was small and sparsely decorated. It was arranged with chairs around the walls to enable people to watch the large television. This arrangement did not encourage conversation amongst people. A large, comfortably furnished lounge area, called the 'Mr C's Club' was also situated on the ground floor. However, we saw this was little used by people living at the service and the seating available was not suitable for everyone to use. The registered manager told us it was intended as a meeting area for people and their families and for social functions. One member of staff said they did not know why the bigger lounge was not used as it was nicer and staff would have more room to be able to use equipment, such as hoists.

Mr C's provided care and support to people who had a mixture of nursing and residential needs. A small number of people were living with dementia. The environment was not suitably adapted to meet the needs of people who were living with dementia. Bedrooms were spread over the four upper floors. They were arranged off long straight corridors which were all very similar in appearance. There was minimal signage to help people orientate themselves. Some signs were confusing and contradictory. For example, the downstairs toilet had a sign under the door handle saying 'Pull', but actually opened with a 'push' motion. There was no sign on the door to indicate it was a toilet. One decorative shop sign reading 'Open', was situated on a cupboard door in the reception that housed the electric boxes for the home. The door was locked, but the key was in the lock and people could have opened the door. Hot and cold water taps in some people's rooms were identical, with no means of telling which was hot and which was cold. There were several different floor coverings on the ground floor for example, black and white checked effect in the reception area, carpet in the lounge and shiny laminate effect in the dining room area. People with dementia may interpret shiny floors as being wet and or slippery and changes in flooring colour as something to step over. Speckles or pebble effects in flooring could look like pieces of litter to be picked up. Flooring on the first floor corridor was uneven and caused an inspector to trip over. Staff said they were careful to watch people when they walked down the corridor.

We spoke with the registered manager about this. They acknowledged the environment was not currently suitable for people living with dementia. Staff and relatives told us one person, who was living with dementia and able to walk around the home, did sometimes get disorientated. They sometimes had difficulty finding their room or getting to the toilet in time. The registered manager took action to correct some of the immediate issues regarding poor signage. For example, they put a handwritten sign on the downstairs toilet to indicate it was a toilet. The 'pull' sign was covered and the 'open' sign taken down.

We recommend the provider ensures the environment is suitable to meet the needs for anyone they consider admitting to the service.

The registered manager told us five people living at the home at the time of the inspection had health conditions that affected their mental capacity to make decisions about some aspects of their care or treatment. We checked whether the service was working within the principles of the Mental Capacity Act

(2005) and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people's human rights may not be fully protected.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Where best interests' decisions are reached, these must be made involving people who know the person well, including family and health and social care representatives where relevant.

Staff told us they had received training in the Mental Capacity Act 2005 (MCA). They knew the basic principles of the Act; that it was intended to support people's right to make their own decisions wherever possible, unless they did not have capacity to do so. They also knew where people were not able to make their own decisions, other relevant people such as families and health and social care professionals, should be consulted in order to reach a decision that was in their best interests. However, documentation did not evidence this understanding was transferred into practice. We saw no evidence of capacity assessments being completed or best interests decisions being reached in a decision specific or individualised way, as they should be to support people's right to make decisions.

Some decisions made on behalf of people to increase their safety, also restricted their movement. For example, in relation to the use of bed rails or a lap safety belt to stop one person slipping from their wheelchair. In these instances, a best interests process should have been completed to consider all factors and check if there were other ways of achieving the person's safety in a less restrictive way. Evidence we reviewed and which the manager had reviewed, suggested the use of bed rails may not have been in the best interests of one person who had become stuck with their legs over them. The assessment should have considered the bed rails may have caused them harm. Staff had not considered whether this decision was in their best interests. People's legal rights were not fully protected because care staff were not applying the requirements of the MCA and MCA Code of Practice.

Applications for Deprivation of Liberty Safeguards (DoLS) had not been made for everyone who legally required this safeguard. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect people's rights to their freedom and liberty and require authorisation from the local authority to restrict liberty should that be necessary to keep people safe. At the time of our inspection, two applications had been made for people who were unable to consent to being in care, received continuous supervision and would be at risk if they left the home unsupervised. However, there were several more people living at the home for whom applications should have been made.

We spoke with the registered manager about this and they told us that people's mental capacity assessments were completed by the registered nurses. The registered manager was aware of the criteria for applying for DoLS and discussed these with us. They were able to quickly identify additional people living at the service for whom applications for DoLS should have been made. Three additional applications for DoLS were made on the final day of our inspection. The registered manager told us they were already aware there were issues in relation to understanding and application of the MCA, as this had been identified through quality audits and the previous inspection. However, this had not been addressed.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff understood the principle that people should be supported to make their own choices and decisions

about their care wherever possible. We heard staff asked people for consent before delivering care and offered people choice to support decision making.

Health and social care professionals gave mixed feedback about the home. Most said care staff were always helpful and communicated well. Two visiting healthcare professionals expressed confidence in the home. One commented "Staff are very approachable and know people as individuals". However, one social care professional expressed concern that one person's needs had not been fully understood or communicated by the registered manager during a recent review. They had been told by the registered manager that this person had no breathing difficulties. They noticed by chance as they were leaving that the person was in fact using oxygen to aid their breathing at times. One GP expressed concerns that their instructions were not always followed or communicated clearly, depending on the individual nurse involved. These concerns were being openly discussed and the GP was visiting weekly to keep oversight of their patients. The registered manager had taken action to support one nurse to develop their practice and confidence.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A range of healthcare professionals visited the home to support people's care and treatment needs. These included physiotherapists, podiatrists, nurse assessors, speech and language therapists, social workers and GP's. During the inspection people told us they got prompt medical attention and relatives said they were kept informed about any health concerns. Prior to the inspection CQC had received a concern from a family who believed their relatives health needs had not been promptly responded to in the period before they passed away. The provider had completed their internal investigation and the family were considering this response. Part of this complaint was in relation to the lack of hot water and call bell system. We have requested a summary of all complaints from the provider.

During our inspection, one person became unwell. The registered manager took appropriate and timely action in order to arrange their prompt admission to hospital. We heard the registered manager making a telephone call to a GP to question the rationale for introducing a new medication for one person that might cause drowsiness. This showed an ability and willingness to question medical opinion appropriately in order to ensure people received the correct treatment.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "Yes, staff seem to know what they are doing", and "The staff turnover is phenomenal, but my care is first class". One person was living at the home on a temporary basis, while waiting to go home. They were very happy with the care they received. They told us staff had been keen to learn about their long term health condition and they had been supported to be as independent as possible. The registered manager told us this had led to this person becoming involved in providing training for new staff to ensure the service users voice was heard.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff said "There's loads of training" and "Training is seen as important here". Each staff member had an individual plan to identify their training needs. The registered manager had systems in place to ensure all staff were trained in the areas identified by the provider as mandatory subjects. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food safety. Other training courses were available to ensure staff were able to meet the specific care needs of the people who lived in the home. These included dementia, catheter care, person centred care, skin care and end of life care, bereavement and diabetes.

We observed moving and handling practice being completed skilfully and confidently by care staff using

appropriate equipment. Staff were unhurried in their approach. They offered constant reassurance to people during the transfer process.

The registered manager had recently recruited new staff. They had carried out a review of staff's skills and knowledge on their first day in order to identify their training needs. There was a comprehensive induction programme for these staff which included face to face training and observations. Newly employed staff members were not permitted to work unsupervised until they had completed induction training and been assessed as being competent to work alone. Many care staff were completing national diplomas in social care or were enrolled to undertake the Care Certificate training programme. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Care staff working at night completed additional training in order to be able to confidently assess when they needed to contact the peripatetic nurse. This included symptoms of dehydration, vital signs, food and fluid charts, and diabetes and head injuries.

Staff received supervision from either the registered manager or a deputy manager. Team meetings were held to provide the staff the opportunity to highlight areas where support was needed and encouraged ideas on how the service could improve. Staff confirmed they had opportunities to discuss any issues during their one to one supervision, appraisals and at staff meetings. Staff told us the registered manager was very busy, but was always contactable and gave information and support when needed.

At the last inspection we found fluid charts did not show people were being supported to have enough to drink. At this inspection the registered manager told us no one was at significant risk of dehydration. The home has a waitress service to support provision of drinks for people during the day. Observations through the day showed fluids were accessible and available for people. Care plans contained specific detail such as ''….always likes two cups of drink next to him……''

People told us they liked the food and were able to make choices about what they had to eat. Pictures of different meals were available to assist those who had communication difficulties. Every morning the chef spoke with people individually about their food preferences for the day. One person said "The food is alright, no complaints there". Another said "The food is good and there's a choice." Where people did not like the main hot meal there was always a range of alternative choices, including baked potatoes, omelettes and pasta. There were also choices available for breakfast and evening meals. Homemade cake was available every afternoon. Hot or cold choices in the evening included baked potatoes, sandwiches and quiche.

Some people had specific dietary needs. The chef had been trained to cater for those needs. For example, where people had a pureed diet, the different elements of the meal were separately set out with separate spoons. Staff who assisted people to eat explained what the foods were and enabled the person to communicate a choice about which foods they would like. Speech and language therapist's (SALT) had provided guidelines in relation to some people's food and drink. Staff were following these guidelines and knew which people needed support or supervision when eating.

Requires Improvement

Is the service caring?

Our findings

Staff were not always able to provide care in a way that ensured people's dignity was protected. For example, on the second day of our inspection when we arrived we found one person downstairs walking by the reception area who was naked from the waist down. There were no staff in the vicinity to be able to protect this person's dignity. This person's family commented they had found him partially undressed when they had visited in the past.

We received mixed feedback from people living at the service about how their privacy was respected. For example, one person said "A lot [of staff] just walk in and don't tap on the door". Another person told us staff always knocked on their door before entering. Although staff told us they always observed people's right to privacy, we saw this was not always the case. On the second day of inspection we observed a gentleman who lived at the service coming out from a bathroom where a member of staff was assisting a female with her personal care. The bathroom door had not been locked to protect her privacy.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and relatives were very complimentary about the staff working at Mr C's. However, staff were working in an environment where there was a culture of acceptance and where people's feedback and concerns were not treated with respect. It had become accepted that problems could not be fixed. This resulted in people at times not having their needs met in a timely way, not having access to working call bells, not having access to hot water and not being able to have showers. Items of clothing and personal possessions were being lost and there was a general disclaimer note saying the home would not accept responsibility for lost belongings. It was undignified for some people to have bedrooms that smelt of urine. Some people found the response to their complaints less than compassionate or helpful. Whilst the manager had responded quickly to some concerns raised by CQC, they had not shown respect to people using the service by taking sufficient action when these concerns had been raised by people or by their relatives.

Some people spoke highly of the care they received. Comments included "The staff have always been very good to me" and, "The staff are nice, and friendly…. I like the staff". Asked if the staff seemed caring, one person said, "Yes, they do. Very kind. They laugh, joke and are very kind." Another person said staff were always "Smiley and happy" and there was a good atmosphere in the home.

We observed staff caring for people during the inspection. Staff addressed people with their preferred name. We saw that staff were cheerful and positive when talking to people, and treated them with respect and affection. People responded to this by smiling and engaging with staff in a friendly, affectionate way. Staff were sensitive to the needs of people while they were in hospital. The registered manager told us they or staff always popped in to visit and reassure people. We saw one member of staff going to take belongings to a person who had been admitted to hospital the previous day. They took another person with them to enable them to visit their wife, who was in hospital at the same time. This gave great comfort to this person.

Staff told us people were at the centre of the care they provided. One member of staff said "We really try to

put the resident first. I always imagine it was my gran or grandpa and how they should be cared for". Staff talked about the people in their care affectionately. They demonstrated they knew the people they supported and were able to tell us about people's preferences and personal histories.

Letters and cards received from relatives thanked the staff for the care provided. Comments included "I want to say a big thank you for the treatment I have had. You've all shown a caring attitude towards me and mine" and "To all the amazing staff at Mr C's – thank you for looking after Dad so well".

Staff told us that, although staffing was sometimes stretched, they never rushed people's care. The interactions we saw confirmed this. Staff were all kind and patient when meeting people's needs. For example, when staff assisted one person to eat their lunch, they spent time sitting next to the person, encouraging them to eat independently in an unhurried way. They gave assistance when requested, whilst supporting the person to do as much as possible themselves.

People who were able to move around the home independently had a key to their bedroom. They could choose whether to remain in their rooms or join others in the lounge.

People were encouraged to retain their independence wherever possible. For example, in relation to assisting themselves to eat and drink and to walk independently. The registered manager told us the service was skilled at supporting people to regain their independence in order to return home and after hospital admissions. There was a small kitchen area on the ground floor which could be used as a practice area for people to regain their independent living skills. Practitioners form the local Care Trust confirmed that the service had supported people to regain confidence and skills to return home.

The hairdresser visited weekly and there was a hairdressing and beauty treatment room in the home. We observed people were enjoying having their hair washed and cut during one day of the inspection. Birthdays and special occasions were celebrated.

There was mixed feedback from people and relatives regarding the level of involvement they had in planning their care. Some people were involved in their reviews; others chose not to be directly involved. Some knew about their care plans and had copies. Other people were not aware, but were unconcerned about this. None of the care plans we reviewed had been signed by people or their representatives. We spoke with the registered manager who said they were working with people and relatives to try and increase involvement. We saw a large sign in the reception area inviting relatives to contact the registered manager to make a convenient time when they could be involved in their relatives care plan review.

Relatives and friends told us they felt welcome and could visit at any time. Some families spent a large part of each day at the home. They said staff were always friendly. There was private space to meet either in people's individual bedrooms or in the large lounge area.

Care staff and the registered manager told us they felt they provided good end of life care and had positive relationships with the local hospice. One member of staff said "End of life care is my passion; it's where we really show our capabilities as carers; making those final days as comfortable as possible for the resident and their family". We saw a small number of people were being cared for in bed due to poor health and all appeared comfortable and pain free. Anticipatory medicines were requested from the person's GP when they were identified as nearing the end of their life to manage their symptoms. These medicines helped people to experience a pain free and dignified death. There were many cards from grateful relatives; thanking staff for the sensitive care provided at the end of their loved one's life.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and care plans developed by registered nurses. Care plans were reviewed monthly and updated when people's needs changed. Care plans were individual to each person and personalised information about people's likes and dislikes and how they liked to be cared for. For example, staff were guided to always stand on one person's right hand side when they were communicating with them, as their eyesight was better on this side. However, the language used within care plans was sometimes highly medicalised. Such language was unlikely to be accessible for people, their relatives or care staff and could restrict involvement in planning of care. Staff said they rarely referred to care plans, which the nurses completed. They told us they relied on the verbal information they received at handover and also on reading the daily records for the previous shift. This meant care plans were not being used meaningfully by care staff and people could be placed at risk of receiving inconsistent care.

One person had a recommended restriction to the amount of fluids they should have each day as part of management of a serious health condition. This person was drinking more than was recommended, which could be detrimental to their health. Staff told us this was their choice. However there was no evidence in the records to show they had received relevant information to enable them to make this decision in an informed way.

The service was not always responsive to people's changing needs. For example, one person had increasing continence needs and was living with dementia. Family members told us they had regular 'accidents' and this meant they could no longer take them out in the car, which was distressing for their relative who loved going out. We noted this person's room smelt of urine on all three days of our inspection. One family member said "My dad smells of urine and his room smells of urine". We looked at how this person's continence needs were being managed. Their care plan said they were usually continent, but "if I don't make it to the toilet in time, I can become incontinent". The registered manager said they were liaising with the continence service about getting new, more suitable continence pads. However, there was no risk assessment or guidance for staff within the care plan about supporting this person to manage their continence more effectively. For example, in relation to regularly prompting or supporting them to get to the toilet in time. We asked staff about this and they said they followed no specific plan to support this person's continence needs.
This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to the inspection we had been made aware of three complaints about Mr C's where relatives were not happy with the way their complaints had been responded to. We found complaints were not always dealt with effectively. There was a clear process for raising complaints and people knew how to complain. 14 complaints had been made since the last inspection. Although these had been responded to, the actions taken to address the areas of concern had not been effective or thorough. This meant the provider was not being responsive to identified concerns and areas for improvement. For example, the manager told us the water temperature, call bells, heating and missing laundry were ongoing trends within their complaints analysis over the past 12 months. One person told us they had complained "innumerable times" about the lack of hot water to have a shower. They said they had been told "We're working on it". This problem had

been going on over several months and was unresolved at the time of our inspection. It impacted on staff's ability to be responsive to people's personal care needs. Similarly, concerns in relation to the call bells not working properly had not been fully investigated or understood. This impacted on staff's ability to be responsive to people's expressed needs.

Two relatives told us they had made complaints about laundry getting lost. They said they had been told the system had improved, but items were still going missing. One relative said "I am always chasing the laundry – they have lost quite a bit". We spoke with the registered manager who showed us how the system had recently been improved. They said the recent issues were due to the housekeeper being off sick over the past few days. On the final day of the inspection the housekeeper had returned to work. The laundry had been tidied and several missing items returned.

One family said their relative's teeth and electric razor were missing and they would need to replace these. We saw during the inspection there was a disclaimer notice on each floor of the building, saying the company could not be held responsible for personal items or laundry that went missing. We talked with the registered manager about this and asked how people who were living with dementia, or physically immobile, could be expected to be responsible for these items. They said we had raised a valid point which they would consider and took these signs down.

Some families told us that they felt the response to their complaints from head office was not helpful, and in some instances the response had not demonstrated compassion or understanding. Two relatives had escalated their complaints externally to the care trust because they were dissatisfied with the provider's response. In order to understand the issues further, we have asked the provider to send us a report of all their complaints and responses.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection we found that there was a low level of social activity in the home and concerns about people being socially isolated. At this inspection we found improvement had been made in this area. Care staff on duty were very busy in the morning as they were caring for people in their bedrooms and helping people get up and get their breakfast. We carried out a SOFI for thirty minutes in the small lounge area. We saw there was minimal interaction from staff for people until staff started getting people ready for lunch. The television was on and people were mostly asleep. However, people did not raise this as a concern and there were more activities available in the afternoons. An activity coordinator had been employed for three days a week and activities were now organised to take place every afternoon during weekdays.

The activity coordinator told us they spent time talking with people about their interests and preferred activities and kept records regarding this in a separate activities folder. This was also used to record individual activities undertaken with people. Records showed an increased range of activities taking place within the home including music and movement sessions, bingo, animal therapy and arts and crafts. Where people did not want to, or could not take part in group activities, we saw there was attention to their individual activity preferences. For example, one person had been reluctant to leave their room but staff had slowly encouraged them to come out of their room. They were now making weekly shopping trips into town accompanied by the activities coordinator. The activities coordinator was arranging for foreign language books to be purchased for a person whose first language was Italian and spending individual time chatting with people in their rooms. Staff said they always talked with people while they were attending to personal care needs. In the afternoons when things were quieter, they spent time talking with people wherever possible.

A keyworker system was in place for people with the most complex care needs. The registered manager told us this had been introduced to provide consistency for health professionals as a point of contact and was working well.

People told us the routines within the home were flexible. For example, they could get up and go to bed when they wished and eat their meals where they wished. They said the deputy manager checked their preferences about when they liked to get up and go to bed, and what foods they liked or disliked, when they first moved in. People said if they changed their mind about what time they wanted to go to bed this was never a problem with staff. On the third day of our inspection we heard one person had raised a concern about their room being noisy. The registered manager took action to respond to this and offered a move to an alternative room, which was accepted.

Relatives told us they could be involved in their family member's care. There was a regular meeting for relatives where they could raise any concerns or ideas they had. Relatives told us they felt able to approach the registered manager, nurse in charge or senior care staff. Relatives were invited to review meetings where appropriate. The registered manager was flexible about the timings of reviews to try to encourage attendance of relatives who may be at work during the week.

Inadequate

Is the service well-led?

Our findings

Mr 'C's has a history of not meeting the regulations over time. Since registering as a nursing home it has been inspected three times. At the inspection carried out in August 2014, we identified the provider was not meeting the regulations in relation to records. At the next inspection in August 2015 we identified these regulations were still unmet. We also identified breaches of regulation in respect of safe care and treatment and staffing levels. The provider sent us an action plan that confirmed improvements would be completed by December 2015. At this inspection in September 2016 we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. We have found people were not receiving a safe, effective, caring, responsive or well-led service.

Providers must assess, monitor and drive improvements in the quality and safety of the services provided. Including the quality of experience for people. They must act on that feedback and use that information to continually evaluate the service and drive improvement. The governance systems in place at Mr 'C's had not been effective in achieving this. Issues relating to risk and quality had not been identified by the governance systems in place. Where the systems had been effective in identifying issues, sufficient action had not always been taken to address those issues. For example, call bells had been tested individually on a regular basis. However, there had been no test of what happened when call bells were set off together. This was despite the registered manager telling us that they had received ongoing complaints from people and relatives about call bells not being answered. The concern had not been investigated thoroughly enough to understand or resolve the issue. Once the issue was understood the registered manager located pagers that enabled the system to operate effectively. However, from May 2014 until the inspection in November 2016, the call bell system had not been fit for purpose. Not all people had not been able to call for assistance and reliably receive a response from care staff.

The registered manager told us issues in relation to hot water had been an ongoing concern, identified through quality monitoring, complaints and feedback the previous year. Despite this, we found hot water was not readily available on one floor of the home during our inspection. We do not know how long this had been a problem. The registered manager said it had only just occurred and was due to a fault with one boiler. This issue was responded to and resolved quickly following the inspection. However, these were reactive responses, triggered by the inspection. The service had not proactively responded to the concerns raised by people living in the service, or their representatives. This meant people's fundamental rights to have a comfortable, quality service were not at the forefront of quality monitoring. There was a culture of acceptance that problems could not be fixed. This resulted in people at times not having access to hot water, items of clothing being lost and the existence of a general disclaimer note saying the home would not accept responsibility for lost belongings.

An audit of files in September 2016 had identified that mental capacity assessments needed to be decision specific. However, this had not been progressed. We spoke with the registered manager about their understanding of the Deprivation of Liberty Safeguards. They understood the criteria for making an application to safeguard people and were quickly able to identify the people for whom applications should be made. Action was taken when prompted to do so through the inspection process. However, there was no

system in place to make sure people were referred in a timely way.

The system for quality assurance of people's records was that the manager randomly selected files to assess for quality and to ensure they were managing risk. However the system had not identified that staff didn't have access to all the information they needed to mitigate risk and ensure that care was provided consistently. The system for auditing care plans had not identified that care plans were sometimes contradictory, not always up to date and not always accurate.

The provider had not considered good environmental design for people with dementia and was unable to explain how they informed themselves about best practice for dementia care or measuring themselves against best practice.

These issues were a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager told us they managed two nursing homes owned by this provider and had a quality monitoring function for another home owned by the company. They split their time between the two homes, spending 2 days a week at Mr 'C's. This was sometimes split into half days. The nurse on duty was the person in charge in their absence. The lack of a consistent manager presence had led to people and their relatives losing confidence in the overall management approach.

People, relatives and visiting healthcare professionals' spoke highly of the registered manager, but all noted how stretched they were. Comments included, "the manager you rarely ever see", "She's trying to do 10 things at once; she does the best she can in the circumstances" and, "The manager is good, but at times ineffectual as she can't be here all the time". Some people lacked confidence in the leadership of the home. Comments included, "They are running on a shoestring. I think it needs some reorganisation" "They could do better". "[Leadership is] not as strong as it should be." One relative said "They (the staff) have a round table conference every morning, but nothing alters things". The registered manager acknowledged the challenge of trying to manage the home on a part time basis. They told us they had been advertising to try to recruit a full time manager for Mr C's for over six months.

Staff gave positive feedback about the registered manager. They felt supported and had confidence in them. Comments included, "I'm definitely confident in [name of registered manager]; she's brilliant and it's good having a nurse for a manager. She understands people's care needs very well" and "If she was here 5 days a week it would be great!" They said leadership was provided by the nurse in charge when the manager was not available. Relatives also spoke highly of this nurse; "She is magic, always smiling."

The director of the company visited regularly and provided supervision to the registered manager and support with quality assurance processes. The registered manager told us they found this supportive. The registered manager also met monthly with an officer from the local Care Trust to ensure clear communication between both parties.

Staff had quarterly meetings where reminders and key updates about practice were shared. Minutes of these meetings did not show these were meetings used to invite ideas or suggestions for improvement from staff. However, staff said they felt they could take forward their ideas and suggestions through staff handover meetings. We saw this was the case. For example, the registered manager invited staff to think about how they could improve one person's comfort levels. Surveys of staff wellbeing had been completed in September 2016. These showed staff were receiving regular supervision and felt supported.

Feedback was sought from people, relatives and health and social care professionals about the service. The registered manager had analysed this feedback and identified reoccurring themes. Although effective steps had not been taken to resolve all areas identified, some progress had been made. The laundry system had been reviewed to try to prevent further loss of people's clothing. Monthly meetings had been set up with an officer from the local Care Trust to ensure effective communication. This was positive practice.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

The registered manager told us they continued to face challenges with the running of the home, such as recruiting a new manager and recruiting and retaining the right staff. The environment was also a challenge which they recognised; "We recognise this building does not work as a standard nursing home". As a result of this, the provider was working with local commissioners to explore whether the setting may be more suitable to provide intermediate care and rehabilitation, as a 'stepping stone' for people between hospital and home.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person-centred.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

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 Care and treatment was not provided to people in a safe way. Equipment in the home was not being maintained in a way that ensured people were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Receiving and acting on complaints Complaints were not always investigated thoroughly or resolved satisfactorily.

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 Records relating to the care and treatment for each person were not accurate and up to date. Effective systems had not been operated to assess, monitor and improve the quality and safety of the services provided. Improvements had not been made to the service to reflect concerns identified in previous inspection reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure people were protected against the risks of recruiting unsuitable staff.

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 Recruitment procedures were not operated effectively to ensure people were protected against the risks of recruiting unsuitable staff.