Care Quality Commission

Eastfield Care Homes Limited

Eastfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 22, 26 and 28 October 2015 and was unannounced.

Eastfield Nursing Home is a care home which provides nursing and residential care for up to 52 older people who have a range of needs including those living with dementia. At the time of our inspection 47 people were using the service.

The service has a 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.

Although people told us they felt safe living at Eastfield Nursing Home, we found risks to people from falls were not always assessed. These were not always monitored in line with the provider's procedures in use to ensure people's safety from the risk of falls and post falls complications.

Summary of findings

There were sufficient staff to support people's needs and keep them safe. However, recruitment procedures were not fully completed to protect people from the employment of unsuitable care staff. The provider had not ensured that a full employment history had been obtained from care staff.

Most staff we spoke with were aware of the signs of abuse and how to report their concerns. Information and guidance on safeguarding people available to staff in the home was not up to date. However, staff training on safeguarding was underway at the time of our inspection.

Risks to people from pressure sores, behaviours that challenge and poor nutrition had been assessed and plans were in place and acted on to reduce and manage these risks. Staff were made aware of people's individual risks and changed needs through daily handover.

There were enough staff on duty to ensure people were cared for safely and their needs were met. People's medicines were administered, dispensed and stored safely.

Staff completed an effective induction into their role. The training required to ensure staff were suitably skilled to carry out their responsibilities was underway at the time of our inspection. Nursing staff did not receive regular supervision to ensure their competence was maintained or to explore and monitor their professional development and concerns. Some nursing staff did not feel they were given an appropriate level of responsibility or that their skills and experience were acknowledged and developed to improve the service. Care staff were subject to ongoing observations of their care delivery to ensure they were competent in their role.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for Deprivation of Liberty Safeguards (DoLS) had been made appropriately. However the provider had not carried out mental capacity assessments and best interest decisions where people's freedom of movement was restricted. This is to ensure people's rights under the Mental Capacity Act 2005 are upheld. For example; people's capacity to consent to the use of bed rails and bucket chairs had not been fully assessed although they can present a restriction to people's freedom of movement.

Some people living with dementia were given a 'soft diet' which was provided as pureed food and were not offered a choice of meal. It was not evident in people's records why they were given a soft diet and whether their food preferences were considered in the meals they were given. People were supported to maintain or gain weight through the use of high calorie and food supplements when they were at risk of poor nutrition.

People had access to the healthcare they required from nursing staff in the home and other healthcare professionals as appropriate for their needs.

We found there was mixed feedback about the caring approach of staff from people and their relatives. We made some observations of practices in the home and staff interactions with people which were not always dignified and caring. This included the uniform use of identical beakers called non-spill cups, to serve a nutrition supplement and people's confidential information being shared in a communal area.

People's needs were assessed and care plans were in place to address their needs. Care plans were not always sufficiently detailed or person centred. Improvements were underway to ensure care plans reflected people's interests and personal histories. People had access to a range of activities provided in the home.

The provider had not effectively implemented quality assurance systems to asses, monitor and improve the quality of the service people experienced. People's care records were not always accurate and up to date. People and their relatives found the registered manager to be helpful and approachable and they felt they were listened to.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe

Risks to people from falling and post falls complications were not consistently assessed or evaluated to ensure people were adequately protected from the risks associated with falls.

People told us they were cared for safely and staff were completing safeguarding training. Safeguarding guidance available to staff in the home was not up to date to ensure staff had access to current information.

There were sufficient staff to meet people's needs. However, not all the required pre employment information relating to staff employed at the service had been obtained. This meant people may be at risk of receiving care from unsuitable staff.

Risks to people from pressure sores, behaviours that challenged and poor nutrition were assessed and managed safely.

People's medicines were administered, stored and disposed of safely.

Is the service effective?

Requires improvement

The service was not always effective.

Nursing staff did not receive regular supervision to ensure their competence was maintained or to explore and monitor their professional development and concerns.

Decisions related to restrictive practices in the home were not always carried out in line with the requirementsof the Mental Capacity Act 2005 (MCA 2005). The principles of the MCA may not have been met in respect of some people.

Peoples needs in relation to the food they were given was not always assessed to ensure it was appropriate for their needs and preferences.

People were supported to address their nutrition and hydration needs.

People had access to the healthcare they required.

Staff completed an induction into their role and were in the process of completing the required training to enable them to carry out their role effectively

Is the service caring?

Requires improvement

The service was not always caring.

Summary of findings

Whilst some staff demonstrated kindness and compassion and a good level of engagement with people others were not always caring in their responses to people. The approach taken to some practices in the home meant that people were not treated with dignity and respect at all times.

People were supported by staff who knew about their interests and preferences and respected their decisions.

People were supported to maintain their independence.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were assessed and their care planned, however care plans were not always sufficiently detailed or person-centred. Improvements were in progress to ensure care plans reflected people's individual interests and personal histories.

People's care was reviewed and staff were updated on peoples changed needs to enable them to provide appropriate care.

People had access to a range of activities to meet their needs.

There were processes in place to enable people to raise concerns they had about the service. Complaints when raised had been responded to in an appropriate manner.

Is the service well-led?

Requires improvement

The service was not always well led.

Effective quality assurance systems were not in place. Shortfalls had not always been identified and actions had not always been completed to drive service improvements.

People's records were not always accurate and up to date to reflect their current needs and abilities

Some staff in the home did not always feel adequately supported in their role and an effective system was not in place to ensure their concerns were addressed and monitored.

People and their relatives said they were listened to by the registered manager who was approachable and available to them.

Eastfield Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 22, 26 and 28 October 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor was a registered nurse with specialist clinical experience of wound management.

Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We had not requested a Provider Information Return (PIR) from the home. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

We spoke with nine people living at Eastfield nursing home, and five people's relatives to gain their views of people's care. We spoke with the registered manager, and 15 staff including, nursing, care, training, activities, maintenance and catering staff during our inspection. We also spoke with a visiting mental health consultant. Before we carried out the inspection we contacted South Eastern Hampshire clinical commissioning group who reported there were no current concerns with the service.

We reviewed 17 people's care plans and the care records of seven people who were at high risk of receiving a pressure injury. We checked12 air mattresses to identifiy their correct and effective use. We observed care being given at lunchtime and throughout the day in communal areas. We reviewed the medicines administration records (MARs) for ten people. We looked at two staff recruitment files and six staff supervision and training files. We looked at the training progress records for all staff. We joined two staff handovers and reviewed policies, procedures and records relating to the management of the service. We reviewed 19 recently completed resident satisfaction questionnaires and considered how quality assurance audits were used to drive improvements in the service.

We last inspected this service on 2nd January 2014 where no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. One person said, "Yes, I do feel safe. I take it for granted, I suppose". Another person said, "The staff are very kind. I feel protected". The relatives we spoke with shared no concerns. One relative said, "We can go away confident that she is looked after and is safe and secure". "Another relative told us, "I haven't really thought about it. That's a good thing as I would if I felt my relative was unsafe".

The processes in place to assess and manage the risks to people from falls were not consistently used to ensure people's safety. There were two systems in place to assess and record people's risks from falls. This consisted of a computerised falls risk assessment and a hard copy fall risk assessment, management plan and post fall protocol and assessment. Computerised accident reports were completed for people who experienced falls. These showed what treatment people received at the time of their fall. Falls risk assessments and post falls assessment documents however had not been consistently completed.

The hard copy falls risk assessment had been introduced in May 2015. This provided a comprehensive assessment of people's risks and a plan of action to reduce their risks from falling. This was used to inform the person's care plan. Records showed however that these risk assessments had not been completed for all people on admission to determine their risk from falls. For example; we reviewed three people's files who were admitted after May 2015 who did not have this risk assessment in place. We reviewed one persons needs assessment which showed they were at risk of injury due to their history of falls, confusion and mobility needs. This person did not have a computerised or hard copy falls risk assessment in place which was required to provide guidance for staff to ensure that any risks of a fall to this person were minimised. This person had then experienced a fall whilst living at the home. One person's falls risk assessment was dated July 2014 and did not include any evaluation of the six falls they had experienced since this time. People were not adequately protected from risks to them from falling because these risks had not been consistently assessed.

Records showed that post falls assessments were not completed consistently for people who had experienced falls. The provider's post falls protocol stated that a post falls assessment should be completed and people observed for 24 hours which should be recorded. For example a person had experienced six falls in the last six months and since their last recorded post falls assessment. There was no record to demonstrate these observations had been completed to ensure the person's health had not deteriorated as a result of their falls. Another person had suffered a fall which had resulted in a cut to their head. Even though the person had their cut seen to at the time of their fall. The required post fall observation assessment to detect any other complications arising from the head injury from the fall was not completed. Non completion of post falls assessments placed these people at risk of not having any post fall complications promptly identified and treated.

Risks to people from falling and post falls complications were not consistently assessed or evaluated to mitigate against any such risks. This was a a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from the employment of unsuitable staff. Although recruitment checks, such as proof of applicants' identity, investigation of any criminal record, previous employer and character references were documented, the two recruitment files we reviewed did not show evidence of a full employment history. The registered manager confirmed this was the system in use. We found the provider's application form required applicants to provide details of their last five years employment only and did not prompt applicants to give a full employment history or a written explanation for gaps in employment. This meant people may not have been adequately protected from the employment of unsuitable staff.

We found that the registered manager had not protected people by ensuring that the information required in schedule 3 of the regulations was available and satisfactory. Notably a full employment history. This is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a training programme in place, which included safeguarding training for all staff and this was in the process of being completed. Most staff we spoke with were able to identify the signs of abuse and were aware they should inform the registered manager of any concerns who would make a referral to an agency, such as the local Adult Services Safeguarding Team. There were written policies

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Is the service safe?

and procedures in relation to safeguarding people. However we noted these were not current. The provider's safeguarding policy was dated 2011 and the local authority multi agency procedures for safeguarding vulnerable adults was dated 2010. The local authority multi-agency policy for safeguarding adults had been updated in 2015 and reflects the requirements of the Care Act 2014 and current good practice in relation to safeguarding people from abuse. This was not available to staff in the home. Current guidance on safeguarding people is important so the provider and staff are aware of any changes in their responsibilities to act on and report abuse.

People's care records showed risks associated with the provision of their care and support had been assessed and recorded such as; pressure sores, daily living, nutrition and hydration. The risk assessments were completed by the registered manager and a nurse and contained guidance for staff to enable them to keep people safe. Staff had access to these risk assessments to enable them to review information about risks to people. People's risks were discussed with staff to ensure the information remained relevant. The registered manager said "Staff are more verbally aware, we talk about it (risks) all the time". This was confirmed by staff we spoke with who were able to tell us about people's individual risks. We observed a morning staff handover given by the registered manager to all staff on duty. Each resident was discussed and this included any risks and particular care needs. This included discussing the action to take regarding one person who was experiencing some pain and required regular observation. Another person was refusing care and staff were advised to give additional time and support to help this person make decisions about this. People were supported by staff who were knowledgable about their individual needs and risks.

Nursing staff spoke knowledgeably about people at risk of pressure sores and how these were treated. The registered manager confirmed there were no people with pressure sores. We checked the electronic care records of seven people who were assessed at high risk of pressure sores and saw there were no current pressure sores reported. We checked air mattress settings and found they were accurate, monitored and recorded daily. Risks to people from the development of pressure sores were being managed safely.

Staff told us about people with behaviours that may challenge staff and described how they delivered care to support people when they presented with these behaviours. For example; a staff member told us about a person who can become aggressive when agitated and said "If you try to hurry them it won't work you have to be patient we now know that and it is in the care plan – they need a long time to take their tablets". A consultant for older people's mental health told us how staff had competently managed some of the most challenging people they had come across. People were cared for by staff who acted appropriately to manage and reduce risks related to people's behaviours.

People and their relatives said there were enough staff on duty to consistently care for people safely. We asked the registered manager how they calculated the number of staff required to care for people safely. We were told this was done in discussion with staff members. One relative said "There is always plenty of staff". Staff were satisfied with the staffing levels and one staff member said "It's the best place I've worked for that. There are loads of staff". Another staff member told us, "There's no problem there". From our observations during lunchtime and throughout the inspection we found the care to be safe and appropriate, with adequate numbers of staff present. People were cared for by a sufficient number of staff to meet their needs safely.

We looked at the arrangements in place to ensure the safe management, storage,administration and disposal of medicines. Medicines were administered to people by nursing staff only. We observed a medicine round and saw the nurse carried this out safely. Medicines were stored in a locked trolley and other medicines were stored in cupboards in a locked room. We found the arrangements for the storage and recording of controlled drugs (CD's) met the legislative requirements. Controlled drugs are subject to additional monitoring because they have the potential to cause serious harm to people if they are misused. The records of these medicines were accurate and when they were administered the record was signed by two staff.

A policy was in place that included guidelines for the ordering, storage, administration and disposal of medicines. The registered manager had circulated The National Institute for Health and Care Excellence (NICE) guidelines for medicines management in care homes. NICE

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Is the service safe?

provides national guidance and advice to improve health and social care. This meant that current guidance was available to support staff in managing people's medicines safely.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be made in their best interests and be as least restrictive as possible.

The provider told us staff had completed training in the Mental Capacity Act 2005. We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA 2005). Two of the staff members we spoke with had a good understanding of the MCA 2005, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Three staff members had little knowledge of the MCA 2005 or its implications for people with little or no mental capacity. Some people we spoke with confirmed staff acted in accordance with their wishes and consent. However, because three staff were unclear about the MCA and its implementation meant the principles may not be applied when appropriate by these staff for the people they were caring for.

Bed rails and bucket chairs were used in the care and treatment of some people. The registered manager told us that people were asked to give their opinion at the time as to whether they wanted bed rails or to be in a bucket chair and told us they were not used to restrain people. Bucket chairs can be a restraint because they present restrictions to people's movement as they can be difficult to get out of and for the person to reposition themselves. Bed rails can be a restraint because they restrict the freedom of movement for the person. The MCA defines restraint as being used if the person's freedom of movement is restricted whether they are resisting or not. Although the registered manager told us the decisions to use this equipment had been discussed with people. Some of the people who had bed rails and used bucket chairs may not have been able to make an informed decision for themselves that included; the risks, complications and alternatives due to their mental capacity. For example we saw accident reports that showed some of these people had fallen whilst using bed rails and bucket chairs and these people lacked mental capacity at times.The MCA requires that in these circumstances a recorded mental capacity assessment and best interest decision making process should be followed. This process should include consideration of whether there was another option that was less restrictive that would meet the need.

The registered manager confirmed that an MCA and best interest decision had been made when a bucket chair was used to restrain a person who was at high risk of falls. This demonstrated the registered manager knew how to act when this equipment was used to restrain people. However, the MCA requires that when a person's freedom of movement is restricted and someone lacks the mental capacity to consent to this, a mental capacity and best interest decision should be recorded in the person's care plan.

Decisions about the use of bed rails and bucket chairs had been made without completing a mental capacity assessment and a recorded best interest decision making process that included the involvement of people or their representatives. The principles of the MCA may not have been met in respect of these people

The failure to ensure where people could not give their consent the registered person had acted in accordance with the MCA 2005 was a breach of regulation 11of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

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

The registered manager had made appropriate DoLS applications for people as required following a mental capacity assessment and a best interest decision process. There were a number of applications outstanding with the local authority. The provider had notified us of the outcome of applications made once this was known.

The provider's staff supervision policy stated staff would receive 'Regular personal reviews and regular feedback and the opportunity to challenge and explore existing practices, policies and procedures'. The provider did not operate the system described in their policy whereby all staff had

regular personal reviews with an allocated supervisor. The registered manager told us individual staff supervision was not planned or recorded. They said "Staff all know they can see me one to one and I don't keep minutes". The registered manager had instructed nursing staff to report any concerns about care staff and their training needs. The registered manager told us they were working towards a system where staff would request individual supervision.

Care staff files included a 'Staff supervision and performance form' which was a checklist record of observations of staff practice in delivering care and this was regularly completed by the registered manager. Care staff we spoke with told us they were adequately supported in their role and were able to discuss their support needs as and when needed with the registered manager.

Supervision is an accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed objectives and outcomes. We were concerned the system whereby staff requested supervision operated by the registered manager may not adequately assure staff competency was maintained.

For example; some nursing staff told us they did not feel 'empowered' in their role to use their professional skills and experience. The registered manager was unaware of their discontent and professional development needs. Nursing staff completed training in the care and administration of medicines however, their competence was not formally reviewed by the registered manager. The registered manager explained their view that professionally trained nursing staff should take personal responsibility for their practice. We found some errors in the recording of medicines. Other medicine management errors had been identified through the provider's own audit. It was not evident that when errors occurred the staff responsible received support and supervision to demonstrate they had the required level of competency to carry out their role. The system operated by the registered manager did not adequately ensure staff received on going supervision in their role to make sure their competence was maintained. This meant people could be at risk of being cared for by staff who were not appropriately supervised to demonstrate and maintain competence in their role.

The failure to ensure staff received appropriate supervision to make sure their competence was maintained is a breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The people and relatives we spoke with gave mixed feedback about their views of how skilled and experienced staff were. One person said, "The staff really know what they're doing. I suppose that's because a lot of them have been here a while". Another person said "It depends who you get. Some are very good but others aren't. I suppose it's the same everywhere." A relative told us, "My mum needs a lot of care now and the staff do it very well". A second relative said, "The established staff certainly know what they're doing but it's not the same with all of the staff".

Staff had completed an induction based on the Skills for Care Common Induction Standards, which are the standards people working in adult social care should meet before they can safely work unsupervised. The training coordinator told us the induction programme was being updated to comply with the Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care that care workers are nationally expected to achieve. One staff member told us, "I had a four day induction. I got a chance to shadow staff at that time and get used to working here". Staff received an effective induction into their role.

The provider used an external training company to deliver training for care and nursing staff across a range of topics the provider had defined as mandatory for their role. Staff we spoke with were mostly satisfied with the training opportunities on offer. Staff had access to further qualifications in health and social care and the training co-ordinator told us the registered manager encouraged this. At the time of our inspection records showed that all staff were in the process of completing the required training.

We asked people about their experiences of food and drink at the home. One person said, "The food is outstanding". Another person told us, "The food is okay. There's plenty of choice". We noted food was served promptly at lunch time, with enough staff present to ensure those who required assistance received it. Lunch was served in two sittings; the first for people requiring the most assistance, the second for those who could manage independently. Main meals were provided ready made by a catering company and

Requires improvement

Is the service effective?

heated and served by kitchen staff in the home. People who were able to choose were given a choice of two options. The kitchen staff told us how they provided other alternatives if a person wanted something different. For example; they told us about a person who preferred salads or chicken meals which they prepared separately.

We saw a list of people for 'Soft diets' was kept in the kitchen. A soft diet is made up of foods that are soft and easy to chew and swallow. These foods may be chopped, ground, mashed, pureed and moist and may have to be followed by people with eating and swallowing difficulties. Kitchen staff told us food for people who required a soft diet was provided pureed and they were not given a choice. The kitchen staff said, "A lot of people on soft diets have dementia and can't give a choice". We looked at the care plans for five people receiving a pureed diet. Care plans did not include information on why a pureed diet was required. For example It was not evident that people given a pureed diet had been assessed by a speech and language therapist (SALT). A SALT can assess the needs and risks of people who have swallowing, eating or drinking difficulties and provide guidance on the consistency of their diet.The registered manager told us nursing staff would make an assessment of whether people required a pureed diet. Where people were unable to make a decision about what and how they ate it was not clear this had been adequately assessed to meet their preferences and needs. This meant people could receive food that did not meet their needs and preferences.

The failure to ensure people's needs in relation to the consistency of their food and their food preferences were assessed and met is a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People at risk of poor nutrition were regularly weighed and their Body Mass Index (BMI) monitored to ensure weight loss was appropriately identified and action taken to prevent deterioration. People assessed as at risk of poor nutrition were given dietary supplements and high calorie drinks. This approach was effective in supporting people to reduce the risk of malnutrition. For example; records showed people had been supported to re-gain weight.

People had access to water in their rooms and hot drinks were regularly served throughout the day. Staff we spoke with were aware of the need to encourage people to drink fluids regularly and to monitor people for signs of dehydration. Nurses confirmed that care staff reported concerns to them when people were not drinking enough fluids.

We asked people and their relatives about their experiences of the health care they received. One person said, "If I need a doctor, they will get it straight away". Another person said, "The doctor got involved with me a while ago. The staff were really good at explaining what was wrong with me". A relative told us, "I know the staff would act if my relative were taken ill. They'd let me know too. The nurses are very good". People's healthcare needs were met by nursing staff in the home or other healthcare professionals as required. Records showed people had attended out-patient clinics and received treatment from GP's when required.

Requires improvement

Is the service caring?

Our findings

We asked people and their relatives about the caring approach of staff. One person said, "Some staff are very kind and gentle. Others seem rushed and are less kind" Another person told us, "It depends who you get. Most are fine and they try to please you". A relative told us, "The staff are caring with my mum, definitely". Some people told us they would like to staff to spend more time talking with them.

We observed interactions between staff and people both at lunchtime and in communal areas throughout the day. We observed excellent interaction between people and some staff who consistently took care to ask people's permission before offering assistance. There was a high level of engagement between people and these staff. Consequently these people appeared able to express their needs and received appropriate care. On another occasion, we observed a staff member ask a person if they wanted some water. The person replied at length after which the staff member repeated the question without addressing the subject raised by the person. We also heard a person being supported in wheelchair say to the staff member "Where am I going" and the staff member ignored them. This meant people were not consistently treated with kindness and respect by all staff.

We observed a number of people receiving drinks in identically coloured, labelled plastic beakers with drinking spouts.These were a non-spill cup. There was no evidence that people's individual needs and preferences for these cups had been assessed. This drink was the nutrition supplement for people at risk of poor nutrition. This was not conducive to maintaining people's dignity. One person's relative told us their family member had objected to the cup and was given their drink in a tea cup. One relative had mentioned this in a completed satisfaction questionnaire, calling the practice "Disrespectful". We observed staff members discussing an afternoon handover in a communal area, despite the very close proximity of at least one person. This was not conducive to maintaining confidentiality and risked disclosure of sensitive personal information to anyone listening nearby

People were not treated with dignity and respect and in a caring and compassionate way at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection a person frequently became distressed and called out for help. Staff responded to the person and tried to alleviate their distress. A staff member sat with the person and we heard them reassure them they were there to 'Look after them'. We spoke to the registered manager about this person who explained they had contacted a mental health consultant who was coming to visit the person to assess their needs as their agitation had increased. The consultant visited during our inspection. This meant action was taken to relieve a person's distress.

Staff told us about some of the people they cared for. This included their preferences and interests. For example; a staff member told us about a person who enjoyed playing the piano and how this helped to calm them when they became agitated. Another staff member told us about how a person enjoyed listening to classical music and we observed this was playing in their room. A staff member said "We will find out about new people, and if they like something or they will tell us". Staff told us they shared information about the things people had enjoyed so that people's preferences were known to other staff.

Some of the people we spoke with were able to tell us the decisions they made with regard to their care and confirmed these were respected. For example; A person said, "Oh yes, I can make decisions for myself and the staff will always ask if they want to do something with me". Another person said "If I don't want a shower or bath on a particular day, the staff are okay with it". A third person said, "There's no question of staff telling me what to do. Of course they need to keep us safe but they let me get on with it."

Relative's we spoke with whose family member was not always able to express their needs and choices said staff supported them to make decisions. For example, a person's relative said, "Staff tend to go with the flow with my relative. It's whatever they want". Another relative said, "My family member can be difficult sometimes because of their dementia and I give a lot of the care but staff let them make choices when they can". A third relative said "They do allow my family member to make the decisions they are capable of, like whom they want to sit next to, when they want to go to their room or stay in the lounge and they do encourage them to eat". People were supported to express their views and make decisions about their care and treatment.

People's privacy was respected by staff. One person told us, "They (staff) always knock before they come in my room

Requires improvement

Is the service caring?

and treat me with respect". Another person said, "I would expect someone to ask before coming in and they do". Our observations during the course of our inspection confirmed this and we observed staff greeted people by name.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them entering the service. Care plans were then developed to identify how people's needs were to be met. Needs assessments and care plans were not always sufficiently detailed to describe why a person required their care to be delivered in a particular way. For example; why people required a soft or pureed diet.

The care plans we reviewed contained some personalised information, however some were too were generic or task led. For example, whilst one person's care plan referred staff to take an interest in a person's hobbies, interests and background, their care plan did not contain any information about these. The person did have a spiritual needs care plan which referred staff to respect the person's beliefs but did not explain what these were. We saw some examples of a 'Person centred plan' this was a paper record of people's history, dreams and wishes, likes and dislikes. The examples we saw had not been fully completed but evidenced progress towards collecting information to develop personalised care planning.

The registered manager told us how they were making improvements to care plans to include people's personal histories, preferences, interests and aspirations. They said "This is a work in progress and has been on-going over the last six months". A person's relatives confirmed they had an appointment to discuss their family member's care plan with a nurse. The registered manager told us they discussed people's planned care with family as appropriate and informally. However, they had recently invited people's relatives to be more formally involved in contributing to their family members care plan development

Staff told us when they noticed people's needs had changed they reported this to the nurses. A staff member said "Its my duty – nurses will ask us or we will report to nurses if there are changes, for example, if we are using a stand aid and this needs to be re-assessed to use a full body hoist". People's care and any changed needs were routinely discussed at handovers. Staff confirmed they were made aware of people's needs through this process. We observed a morning staff handover and noted each person was reported on and this included any issues or concerns.

The electronic system used to record people's care plans prompted reviews which were carried out by the registered manager and one nurse. Other nurses would also enter information to update the care plan, for example following a GP visit. Care staff or nurses recorded day and night notes to report on the care delivered and people's progress. However, we observed these entries were often selected from a standard drop down menu rather than an individualised account of people's care. Records contained descriptions such as 'slept well / bowels open / mattress checked' but very little to describe or evaluate people's daily care in line with their assessed needs. For example; some people's care plans and risk assessments stated that daily records should reflect whether they had eaten well and if their fluid intake was good in line with their assessed needs and risks and this was not reflected in the daily recordings. In the care plans we reviewed where people were treated for a pressure sore there was no description or evaluation of the care they had received other than 'care as planned'. This information is important to provide an evaluation and outcome of the effectiveness of the care and treatment people received.

Staff were able to tell us about people's needs and how they responded to them. For example; who was at risk of pressure areas and how this was managed. Summary information was recorded in each person's room on their personal care and mobility needs for staff to refer to. During our inspection we observed that nurses were responsive to people's healthcare needs. For example; a relative called a nurse to ask for pain relief for their family member who was experiencing pain. The nurse confirmed when they last administered pain relief and they had also taken the person's blood pressure and tested their blood sugar. The nurse contacted the GP, spent time with the person to reassure them and provided pain relief. People told us they received the care they needed and people's relatives confirmed this.

Care plans included the strategies staff should use to support people if they behaved in a way that challenged others. A visiting consultant for older people's mental health told us the staff acted proactively to meet people's needs when their behaviour changed. They said physical reasons for a persons change in behaviour such as illness would have been excluded before they were contacted to review the person's needs. The consultant told us effective and responsive care was provided for the people they reviewed who had behaviours that challenge.

Requires improvement

Is the service responsive?

An activities programme was in place, this included group activities such as; musical events, coffee mornings, cookery sessions, arts and crafts and quizzes. Individual activities were also available such as; aromatherapy, reflexology and visits to people's rooms from a harpist. The activities worker told us "I do one to one sessions when people are bed bound. I get to know people and their relatives tell me what they like and need, for example I go shopping with a person who enjoys this".The home had a Hydro therapy pool. The registered manager told us this was particularly helpful for people who had experienced a stroke. Staff supported people using the pool as physiotherapy was not provided. The registered manager said it was "More for people's pleasure".

People's rooms were personalised and decorated with the objects they valued and a relative said "They let my relative bring pictures and things". The home had large grounds and the registered manager told us about their plans to develop an enclosed garden for people to use independently and to keep more animals as people enjoyed visiting the chickens which were kept in the grounds.

We asked people's relatives about how the home managed concerns and complaints. One relative said, "The manager is very open and honest. I did have a few issues when my family member first came here. I discussed them with the manager; they put it right. There hasn't been a problem since". Another relative told us, "The manager will always listen. There's no doubt about that". Information and guidance was available to people and their relatives on how to make a complaint and who to complain to. When people raised complaints they were recorded, investigated and action taken to address them.

Requires improvement

Is the service well-led?

Our findings

At the time of our visit an effective governance system to monitor and improve the quality of the service and the risks to the health and safety of people was not in place. The registered manager was able to demonstrate that some audits had been undertaken. However the issues identified in the audits were not always acted on to prevent a reoccurrence and make the identified improvements. Audit records had not been fully completed to evidence action was taken to make the identified improvements.

A health and safety audit had been completed by an external consultant with recommendations for action to be completed in July and September 2015. However these had not been recorded as completed. One recommendation required the urgent updating of the information about the Control of Substances Hazardous to Health information (COSHH). We looked at the COSHH file and saw this had not been updated. An infection control audit was carried out by a nurse who e-mailed the findings of the audit to the registered manager. We reviewed the last two audits carried out in February and October 2015. The October audit had identified some areas for improvement such as; cleanliness of the sluice and tidiness and cleanliness of people's bedrooms. The audit carried out in February had also identified these concerns as areas identified for improvement. However, an action plan was not produced from the audit. It was therefore not clear what action had been taken to make and sustain the required improvements and the concerns were on going.

Records showed a medicines audit was carried out by nursing staff. We looked at the records of the last three audits in February, March and June 2015. The audits were carried out by nursing staff who e-mailed the findings from the audit to the registered manager. The audits identified some areas for improvement which also appeared on subsequent audits such as; bottles of medicines not dated when opened, and gaps in recording of when medicines were administered. However, there was no action plan detailing how improvements were to be achieved, by whom and in what timescale. Recommendations had been made to improve practice but it was not clear how these would be actioned or monitored. An audit on medicines management had been carried out by a Pharmacist in July 2015. Improvements had been made as a result of this audit. However, actions to remedy the issues they identified had not been fully completed or effectively monitored. For example; one person who had been resident since August 2015 did not have a photographic image with their MAR sheet and a change to a person's medication had not been signed by two staff.This meant that when actions were identified to improve the quality and safety of the service people received they were not always acted on and monitored.

Whilst records showed that staff were in the process of completing required training. We noted the 'Staff progress chart' in use did not provide effective monitoring of the required training. Records were not dated to evidence when staff had received training or when they had completed it. For example; records reflected a low rate of completion in some topics such as; safeguarding adults, diet and nutrition, basic emergency aid and infection control. This meant the system in place to ensure people were supported by staff who had completed the required training to enable them to carry out their role was not effectively monitored.

People's care plans did not always contain accurate and up to date information about their care and treatment needs. For example; a person's diabetic care plan had not been updated with accurate information about their blood glucose levels, or current insulin regime. This person's blood glucose levels were frequently higher than the range described in their care plan. This had been addressed with the GP. Whilst staff were acting on the updated guidance from the GP the person's care plan did not accurately reflect their current care and treatment needs. We noted that one persons care plans indicated they had lost two stones in weight. When we asked the registered manager to check this they discovered the persons weight had been recorded incorrectly and they had not lost weight. Records about a person's risks in relation to their mobility was not clear for example; the computerised falls risk assessment stated the person was 'mobile with walking aids' we were told by a nurse the person was 'stand to transfer' only. The person's pressure care risk assessment stated 'immobile using full body hoist'. People could be at risk of inappropriate care and treatment if their records are not accurate and up to date.

The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. Care records did not always accurately reflect the care and treatment provided to the person

Requires improvement

Is the service well-led?

including the decisions taken in relation to the care provided. These shortfalls are a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Two nursing staff told us they felt 'Disempowered' by the management approach taken. Their dissatisfaction was centred on their lack of responsibility for developing and reviewing people's care plans which was carried out by the registered manager and one nurse. Some nursing staff also told us they did not feel they were listened to when they made suggestions for improvements and changes. A nurse said "I am not involved enough as a nurse, I feel I am being deskilled. I try and implement and make suggestions but these are not accepted. I have nothing to do with care plans. Another nurse said "I can say I am satisfied here but professionally I gained far more from working in other homes. I think support for nurses to use their own initiative would increase self-esteem and if we were appreciated and acknowledged more it would be a motivator". The registered manager said that staff had the opportunity to raise ideas, suggestions and concerns about the management of the home at the daily meeting held to allocate work and update staff on people's needs. Other planned team meetings were not held and staff did not have allocated time for individual or group supervision.The lack of planned and recorded processes to enable all staff to raise issues and concerns, contribute their views and receive feedback about these could mean issues affecting staff may not be addressed or kept under review.

People and their relatives confirmed the atmosphere in the home was comfortable and homely. The registered manager explained the philosophy of the home was centred on 'Relational care'. Relational care focuses on the relationship between the carer and the person. The registered manager said "We try to foster close relationships with people and allow people to be as informal as possible to create a home so people can feel at home". The registered manager worked as a nurse as part of the daily team, they did this to cover a vacant post and but also to influence the culture and the way people were cared for by staff. They said "I raise staff awareness and encourage staff to think beyond 'labels' such as 'dementia' and 'challenging behaviour' to the person, and I encourage staff to think about their colleagues, in this way we all develop the service".

People and their relatives told us they could speak to the registered manager and felt they were listened to. For example a relative said "The manager was good he spent a long time talking to us explaining and reassuring us about mum's mental confusion in relation to why she was in the home". Another relative said "From our interaction with the registered manager we find he is hands on and he is around. We asked to see him and he was changing someone's dressings – he has got the practical knowledge. He does not give a text book response I feel he knows what he is talking about".

We reviewed a service evaluation report dated 26th August 2015 based on feedback from people and their relatives. Feedback had been given about ways to improve the service and what people were dissatisfied with. We discussed this with the registered manager who told us some actions had been taken in response to this feedback such as; improving activities and informing family of GP visits. This evidenced the registered manager had analysed the information gathered and acted on some of the issues raised. However the evaluation report did not include information on the actions taken in response to the feedback and following the review. This report was circulated to people and their relatives. This meant that whilst people were made aware of the results of the review they were not informed of the actions taken in response to their feedback.

Staff were aware of whistle blowing procedures and confirmed to us the manager operated an 'Open door' policy and they felt able to share any concerns they may have in confidence. We noted the whistle blowing policy stated 'Bad practice should be reported to the nursing home manager or person in charge'. The whistle blowing policy did not include information to enable staff to raise concerns outside the organisation to the Local Authority where necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met: The provider had failed to ensure people's needs and preferences in relation to the consistency of their food and their food choices were assessed, appropriate and met.Regulation 9 (1) (a)(b)(c) and (3)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met: People were not treated with dignity and respect and in a caring and compassionate way at all times. Regulation 10 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met: The provider had failed to ensure where people could not give their consent they had acted in accordance with the 2005 Act. Regulation 11 (1) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: People who use services and others were not protected against the risks**

This section is primarily information for the provider

Action we have told the provider to take

associated with falls because risks to people from falling and post falls complications were not consistently assessed or evaluated to mitigate any such risks. Regulation 12 (1)(2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. Where risks to the quality and safety of the service people received were identifified. Effective measures were not in place to ensure these were mitigated and addressed. Care records did not always accurately reflect the care and treatment provided to the person including the decisions taken in relation to the care provided. Regulation 17 (1) and (2) (a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure all staff received appropriate support and supervision to enable them to demonstrate and maintain competence in their role. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: People who use services were not protected against the risks associated with unsuitable care staff. The information specified in Schedule 3 was not available, notably a full employment history. Regulation 19 (2) (a).