Eldercare (Halifax) Limited

Elm Royd Nursing Home

Inspection report

Brighouse Wood Lane
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West Yorkshire
HD6 2AL

Tel: 01484714549

Date of inspection visit:
13 December 2016
20 December 2016

Date of publication:
03 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on 13 & 20 December 2016, both days were unannounced.

Elm Royd Nursing Home is registered to provide nursing and residential care to up to 50 older people and people who may be living with dementia. There were 38 people living in the home on the first day of the inspection and 39 on the second.

The service has not had registered manager since September 2013. However, at the time of this inspection there was a manager in place and their application for registration was being considered by the Commission. 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 last inspection was in April 2016 and during that visit we found that overall improvements had been made since October 2015 when we rated the service as inadequate and placed it in special measures. In April 2016 we found one breach of regulation in relation to the safe management of people's medicines. This inspection was carried out to check if the required improvements had been implemented and sustained. We found they had not.

People's medicines were not managed safely and we could not be assured people were receiving their prescribed medicines properly.

Risks to people's health, safety and welfare were not properly identified or managed. For example, we found two free standing heaters with very hot surface temperatures in use. Action was not taken to address this risk until we brought it to the attention of the home manager. In another example, we found when people had pressure relief equipment, such as mattresses, in place there was no information in their care records to show the correct settings.

We found there were not enough staff on the first floor to meet people's needs. When we raised this with the management team on the first day of the inspection they told us they had just carried out a review of people's dependency which showed they needed more staff on the first floor. However, when we returned on the second day the staffing had not been increased.

People who used the service told us they felt safe and the staff we spoke with knew how to recognise and report abuse. The provider had robust recruitment procedures in place and new staff received induction training. However, after induction we found staff did not consistently receive the training and support they should have to carry out their duties effectively.

We found people were not always supported to meet their nutritional needs. When people's food and drink

intake was being recorded there was no evidence the records were being checked to make sure people were having an adequate diet.

The home was working in accordance with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were asked for consent and their wishes were respected. When people lacked capacity decisions made in their best interests were recorded.

People had access to the full range of NHS services. People were supported to plan how they wanted their end of life care to be delivered.

We saw some good interactions between staff and people living in the home. However, we also saw examples of practices which did not respect people's dignity. Although there was a programme of activities people with more complex needs did not always get the support they needed to meet their social needs.

We found people's care records did not always reflect their current needs and care was not always delivered in line with people's assessed needs.

There was a complaints procedure in place. People who lived in the home told us they had no complaints. Relatives who had raised concerns with the manager told us they were satisfied with the action taken.

People who lived in the home and their relatives were given the opportunity to share their views of the service by way of meetings and surveys. However, we found no action had been taken in response to issues raised in surveys people had completed in September 2016.

We found the provider did not have good governance systems in place which would enable them to monitor, assess and improve the quality of the services provided.

During this inspection we found the provider was in breach of six regulations. There were Regulation 12 (Safe care and treatment). Regulation 9 (Person centred care), Regulation 10 (Dignity and respect), Regulation 14 (Meeting nutrition and hydration needs), Regulation 17 (Good governance) and Regulation 18 (Staffing). The Commission is currently considering the appropriate regulatory response to the issues we identified.

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's medicines were not managed safely and we could not be assured people always received their medicines as prescribed.

Risk to people's health, safety and welfare were not managed effectively.

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

People told us they felt safe and staff knew how to recognise and report abuse.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive the right support to ensure they were receiving adequate amounts of food and drink.

Staff were not receiving the training and support they needed to carry out their roles effectively.

People were asked for consent and their right to refuse care and treatment was respected. When people lacked capacity decisions were made in their best interests in consultation with their relatives and others.

People had access to the full range of NHS services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us the staff were caring and we observed some good interactions between staff and people who used the service. However, we also observed some interactions which did not show respect for people's dignity.

Information about people's past lives was recorded to help staff get to know people as individuals. However, we found people were not consistently supported to meet their cultural needs.

People who lived in the home told us they were not involved in their care planning. However, the majority of relatives we spoke with told us they were kept well informed and were involved in decisions about care and treatment.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not reflect their current needs and care was not consistently delivered in a way which met people's needs.

People with more complex needs did not always get the right support to meet their social needs.

There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to ensure they complied with legislation and to assess, monitor and improve the quality of the services provided.

Elm Royd 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 13 and 20 December 2016 and was unannounced on both days.

The inspection team consisted of two inspectors 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, in this case services for older people.

During the inspection we spoke with nine people who lived in the home and six relatives and observed people's care and support in the communal rooms. We also spoke with four care assistants, three nurses, the cook, a team leader, the activities organiser, the administrator, the maintenance man, the home manager and area manager.

We looked at nine people's care records including care plans and risk assessments. We looked at a selection of medication records, food and fluid charts and records relating to the day to day running of the home such as duty rotas, training records, meeting notes, surveys and maintenance records. We looked around the home including a selection of people's bedrooms, communal living rooms, bathrooms and toilets.

Before we visited the home we looked at the information we had about the service which included notifications they had sent us. We received information from the Local Authority safeguarding team and the contracts and commissioning department. On this occasion we did not ask the provider to complete a Provider Information Return. 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.

Inadequate

Is the service safe?

Our findings

At the last two inspections we had concerns about the way in which people's medicines were managed. During this inspection the nurse on duty told us the medication system had been changed from individual boxed medicines to blister packs and said this had been in place for one month. We saw the majority of medicine administration records (MARs) were printed by the pharmacist. However, we saw two people who had recently been admitted to the home had handwritten MARs and their medicines were boxed rather than in a blister pack. We checked these medicines with the nurse and found several discrepancies as stock levels did not tally with the amounts recorded on the MARs. For example, for one person there were seven more tablets in stock for one of their medicines than there should have been according to the entries on the MAR and for another there were two fewer tablets. Both of which indicated the person had not received their medicines as prescribed. The stock levels we checked for the other person were also incorrect. For one medicine there were five more tablets left than there should have been according to the stock levels recorded and the number of tablets signed as given. This indicated the medicine had not been administered as prescribed. We found similar discrepancies with five other medicines prescribed for this person and found two other medicines had not been given for four days as the home had run out of stock. We raised these issues with the manager. When we returned on the second day we found these two medicines had been obtained, however, the person had run out of three of their other medicines. One had been out of stock for five days, another for three days and the third for two days.

We saw another person was prescribed a pain relieving medicine to be given 'as required' up to four times a day. The MAR showed this had only been administered twice in the 19 days leading up to the inspection. We looked at this person's care plan which showed their arthritis caused them severe pain when staff were assisting them with washing and dressing and we heard this person calling out as staff were attending to their personal hygiene needs. The nurse confirmed the person shouted out every time they were moved but could not explain why this medicine had not been administered when the person appeared to be in pain.

We saw topical medicine administration records (TMARs) were in place for prescribed creams and lotions applied by care staff. However, the information provided was not clear where these creams should be applied or how often. For example, one person had TMARs for three different creams, all of them stated 'use as directed' and there was no further information recorded or shown on the body maps. The TMARs were incomplete and on several occasions the staff had signed to say the creams had been 'offered but not required' yet there was no further explanation as to the reason why. We saw one of the creams in this person's bedroom was prescribed for another person.

Most medicines were stored securely and the temperatures of the medicines fridges were monitored to make sure medicines were stored at the recommended temperature. However, there was no monitoring of the room temperature in the clinic room on the ground floor. This had been picked up during the home's internal medication audits in October and November 2016 but had not been addressed.

Some people who used the service were prescribed thickening agents because they had difficulty swallowing. We saw these medicines were stored openly in people's bedrooms and in the dining room

which meant they were accessible to other people using the service. Thickening agents are prescribed medicines for individual use only and need to be kept securely.

Some medicines were prescribed to be taken 'as required' (PRN) and in majority of cases we found there was guidance in place in the form of PRN protocols to make sure they were used consistently. However, in one person's records we found that although there was a protocol in place for the use of inhalers there was none for their pain relieving medication.

There were 'PRN/Medication Stock Balance' forms in place where staff were required to record the dose administered and maintain a running stock balance. However, in two cases we found these records were not maintained accurately and there was no evidence that significant discrepancies in the recorded stock balances had been investigated.

We concluded people's medicines were not managed properly and safely. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and a random selection of stock and found they were correct.

We looked at the records for one person who received their medicines covertly (in a disguised format). The records showed the decision to administer medicines in this way had been taken in the person's best interests with the involvement of staff, relatives and health care professionals.

We found risks to people's health and safety were not managed properly. We saw two free standing radiators were being used in some areas of the home and we found the surface temperature of these radiators was very hot to touch. One was placed in the doorway to a dining room and the other was in a person's bedroom. We brought these to the attention of the manager who took immediate action to remove these devices. However, we were concerned the risk these radiators presented to people had not been considered or addressed until we raised it.

We saw pressure reliving equipment such as specialist mattresses and cushions was in place for people who had been assessed at risk of developing pressure ulcers. However, there was no information in people care records to show the correct settings for this equipment and when we asked one of the nurses they said they did not know what the settings should be. We saw the pressure relieving mattress for one person was set to firm which we considered was not compatible with their low weight and when we discussed this with the nurse they agreed.

One person's care records showed they were at high risk of falling and were receiving continual one-to-one support. We saw they had fallen on one occasion in October 2016 and the records showed three further falls in November 2016 although the circumstances of two of these falls were not clear. There was no information in the care records to show the risks had been reassessed or risk management plans had been reviewed following these incidents.

In another person's records we saw they should have a sensor mat in their chair because they were at risk of falling. We saw the sensor mat was on the chair in their bedroom although the person was in the dining room in a wheelchair. We asked one of the care staff and they told us they were not aware the person should have a sensor mat. They put the mat in place after we brought it to their attention.

When we looked at the maintenance records we saw the electrical wiring installations had been checked in May 2016. The report dated 23 June 2016 stated the overall assessment of the installation in terms of its suitability for continued use was 'unsatisfactory'. The recommendations section of the report identified 10 action points, three were classified as C2 'potentially dangerous and requiring urgent remedial action and the remaining seven were classified as C3 'improvement recommendations'. We asked the area manager what action had been taken to address the report recommendations. They told us an external contractor would be visiting the home on 10 January 2017 to rectify the shortfalls. We asked why there had been a delay of over six months in addressing the recommendations and they told us this was due to problems with a previous contractor.

When we arrived at 8am on the second day and went to the first floor we heard banging coming from one person's room. We knocked and went in and the person told us they were cold and wanted a blanket. The radiator in the room was cold. All the staff were in handover downstairs apart from one staff member who was working in a supernumerary capacity writing care plans on the computer. We alerted them to this person and staff brought an extra blanket. The person told us they had been cold all night. We went into the dining room where there was one person in a wheelchair at the dining room table. The person was saying, "Oh it is cold". The radiators in the room were cold. We found some areas of the home were warm whereas others were noticeably cold and there was no hot water in the rooms where there was no heating. Although the manager in the morning arranged for staff to provide additional blankets and warmer clothing for people and told us they had arranged for additional heaters to be purchased, we were concerned that this had not been put in place sooner. The handy person told us there had been problems with one of the boilers the previous morning and the engineer had not been able to visit that day but was booked to come the morning of our inspection. Staff we spoke with confirmed there had been problems with the heating and hot water the previous afternoon and evening. The day after our visit the manager confirmed the necessary repairs had been carried out and the heating was working.

We concluded the provider was not taking appropriate action to mitigate risks to the health, welfare and safety of people who used the service. This was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other checks were undertaken on the premises and equipment and these were up to date. They included checks on the gas and water systems, fire safety equipment, the nurse call system, the passenger lift and hoists and slings.

We saw personal emergency evacuation plans (PEEPS) in people's care records and the team leader told us a copy of each person's PEEP was also kept in a central file known as the fire box.

We found there were insufficient staff deployed to meet people's needs particularly on the first floor of the home. We saw the majority of people accommodated on this floor stayed in their bedrooms with only three or four people using the communal areas and staff we spoke with told us this was usual. Staff told us all of the 21 people on this floor required two staff to assist them with personal care and 15 of these people required staff assistance with their meals. We saw the four care staff assigned to this floor were constantly busy especially at mealtimes. Staff told us they felt more staff were needed on this floor due to people's dependencies and the layout of the unit. When we raised our concerns with the manager at the feedback session at the end of the first day they told us they had reviewed people's dependencies that morning and would be increasing the staffing levels on this floor.

However, when we returned on the second day we found the staffing levels had not been increased. We saw staff were extremely busy and again found the majority of people on the first floor were nursed in bed. When

we asked the nurse why this was they said it was 'down to time' and said they did not have enough staff to get everyone up as everyone on the first floor needed two staff to assist them. This level of dependency was confirmed by other staff we spoke with who told us they were constantly rushing and did not have time to talk with people except when they were assisting them with personal care.

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

At the last inspection in April 2016 we checked five staff files and found the required checks were completed before new staff started work. These included checks with the DBS (Disclosure and Barring Service) to make sure prospective staff did not have any criminal convictions which would mean they were unsuitable to work with vulnerable adults. Prior to this inspection the local authority shared information with us which confirmed the service continued to operate robust recruitment procedures. During this inspection we did not check any staff recruitment files. However, the manager provided us with information which confirmed DBS checks had been undertaken for all the staff. In addition, they provided records which showed they had carried out checks with the NMC (Nursing and Midwifery Council) to make sure all the nurses employed were currently registered.

People who used the service told us they felt safe. One person said, "The doors are always locked, no one can come in to harm you, I feel alright me." Another person said, "I couldn't feel more secure and its way cleaner than the place I was before." A third person said, "The atmosphere is very friendly, people are friendly with each other."

Staff spoken with understood what safeguarding was and knew how to report any concerns both within the organisation and to external agencies if necessary. Staff received training on safeguarding as part of their induction training. Our records showed the service was making referrals to the local authority safeguarding team when there were any concerns about people's safety. The local safeguarding team and they confirmed they were receiving appropriate referrals from the service.

Inadequate

Is the service effective?

Our findings

There was a training matrix in place with showed the mandatory training staff were required to do. This included fire safety, food safety, moving people safely, safeguarding, infection control, the Mental Capacity Act and first aid. However, when we looked at the training matrix we found gaps in training. For example, three of the seven nurses had not completed training on care planning and one was overdue an update since March 2016. The matrix also showed three of the seven nurses had not completed training on documentation, communication and reporting and person centred care planning and four had not completed training on tissue viability.

At the last inspection in April 2016 the manager who was in post told us they had put a plan in place to make sure staff received supervision at regular intervals and to ensure all staff had an annual appraisal. The provider's policy stated staff supervision must take place at least six times a year.

We spoke with one member of staff who told us they had been working at the home for approximately nine months. They told us they had undertaken training to help with their role; however they said they had only taken part in one supervision meeting and that had been just a few weeks before our inspection.

We looked at the supervision and appraisal schedule and found there was an inconsistent approach to the delivery of staff supervision and while a small number of staff received regular supervision the majority did not. The schedule also showed only nine staff had received an appraisal in 2016.

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager acknowledged both staff supervision and appraisal were behind schedule and said they had a plan in place to address this.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The manager maintained a list of all DoLS applications and the expiry date of DoLS authorisations which had been granted. When we looked at the handover sheet we found the recording of information about DoLS authorisations and any conditions attached was inconsistent. This meant the information was not always easily accessible to staff which could result in people's rights being compromised. This was

discussed with the manager who said they would address it.

We spoke with the relative of one person who had a DoLS authorisation which had been granted with conditions. They said they had been kept fully informed about the DoLS process and told us what was being done to comply with the conditions.

We saw detailed mental capacity assessments and best interest decisions recorded for specific decisions such as the use of bed rails. We saw staff explained what they were going to do and sought consent from people before providing assistance. For example, we saw when staff brought people into the lounge they asked them where they would like to sit. We saw people were asked if they would like a clothing protector on at mealtimes. We also saw examples of staff respecting people's right to refuse care or treatment. For instance, one person was assessed as having a high risk of developing pressure sores and an air flow mattress was recommended. However, the person chose to have a foam mattress. The records showed the risks had been explained to the person and they had the capacity to make an informed decision. We spoke with the person and they confirmed the information contained within their care records.

Staff we spoke with told us they had received training in the MCA and DoLS.

We found people's nutritional and hydration needs were not always being met. One person's weight chart showed they had lost two kilograms in weight over a six week period between October and December 2016 and their body mass index (BMI) was 16 which was very low and placed the person at high risk of malnutrition. Their nutritional care plan stated they were on a fortified diet and their food intake was to be recorded. We looked at the food and fluid charts for this person over a six day period and found these were poorly completed and some days reflected very little intake. For example, one day's intake was recorded as a bowl of porridge, three quarters of a main meal and a quarter of pudding at lunchtime and three quarters of a main and a few spoonfuls of pudding at tea time. There were no regular snacks recorded between meals. There was no evidence of analysis of the food charts to ensure people were receiving sufficient food and drink.

In the case of another person there were inconsistencies in the records which meant we were not able to get a clear picture of their weight or nutritional status was. The MUST assessment dated 5 October 2016 recorded their weight as 75.8kg with a BMI of 25. However, the weight record dated 6 October 2016 showed the person's weight as 66.1kg. Similarly on 17 December 2016 the MUST assessment showed the person's weight as 62.6kg with a BMI of 20 while the weight record dated 19 December 2016 showed their weigh as 72.9kg. The person's nutrition care plan dated 5 October 2016 stated one of the goals was to 'maintain weight at optimum level' but there was no indication of what this was. The care plan had been reviewed on 30 November and 17 December 2016 but the reviews made no reference to the differences between the MUST assessment and the weight records or to other inconsistencies on the weight records.

We found insufficient consideration was given to the gap between meal times which meant people were not always receiving three full meals a day. For example, on the first day of the inspection saw one person in the dining on the ground floor was having their breakfast at 10.30am. They had scrambled egg and toast for breakfast and while they were eating they were asked what they wanted for lunch. Lunch was served at approximately 12.30pm and staff told us the person had only eaten a quarter of their lunch. We looked at the person's food and fluid intake charts completed over an eight day period and saw this pattern was repeated. There were no times recorded on the food and fluid charts completed during the day. There was no evidence the food and fluids charts were analysed to ensure people were receiving an adequate amount of food and drink.

The menus displayed downstairs showed a varied choice of meals and there was information kept in the office which showed how meals and snacks could be fortified to provide extra calories and protein for people who were nutritionally at risk. However, we found this did not reflect what was actually provided to people. For example, the information sheets showed toast, scones, crumpets and pancakes with extra butter and jam were available to people mid-morning and afternoon. Yet we saw none of these offered to people on either day of our inspection, nor were any of these snacks reflected on the food charts we reviewed. When we asked staff they told us biscuits, yoghurts and sometimes cake were available as snacks.

On the first day of the inspection we spoke with the staff member who was cooking that day. They told us they were not the usual cook and were covering as the cook was off. They showed us a list of people's dietary requirements displayed in the kitchen. This showed if people were diabetic or required pureed meals and thickened fluids. The staff member told us there were no other specialist diets. We asked the staff member if they knew which people were low weight or who needed extra calories. They said they did not know and said this information was not provided. We asked if they provided extra calories or fortified meals for any people. They told us they added cream to potatoes but said this was provided to everybody. We asked how they made the porridge and they said with water, milk and porridge oats and this was the same for everybody. We asked what snacks were available to people between meals and they said biscuits and at supper time left over sandwiches from tea.

There were no menus displayed on the first floor and when we asked staff what was for lunch and tea they were not sure until the meal arrived. At tea time we spoke with a relative who was assisting their family member with their meal. We asked what the meal was and the relative said they did not know as there were no menus upstairs and staff had not said when they gave them the meal. We asked two staff members what the meal was and neither knew until we suggested the meal the cook had told us was for tea. On the second day we asked a staff member who was assisting a person with their pureed food what the meal was and they said it was carrots, peas and potato. When we asked if the meal had any fish in it as other people who were not on a pureed diet had fish, they said no the person could not have it as they needed their food pureed.

This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care records we reviewed showed the involvement of health and social care professionals such as the GP, tissue viability nurse, speech and language therapists, optician and chiropodist. This was confirmed by our conversations with relatives of people who lived at the home.

Requires Improvement

Is the service caring?

Our findings

We saw the majority of people looked clean and well-groomed which showed consideration was given to people's dignity. We asked people if staff treated them well and respected their privacy and dignity and the answers were positive. One person said, "[The] staff are great, polite and caring." Another person said, "Staff always ask you, have you had breakfast or do you want and drink?" A third person said, "Staff are very helpful."

We observed some kind and caring interactions between staff and people who used the service. We saw one staff member brought lunch for a person who was sat in the lounge. They spoke patiently and kindly with the person, explained what the meal was, asked if they wanted their food cutting up and offered different condiments. We saw another staff member brought in a pureed meal for another person. They described the different parts of the meal and we heard the person say, "That sounds nice." We saw the staff member had a lovely manner as they assisted the person asking them if they were ready for another mouthful and if they were enjoying it.

In contrast we saw poor interactions from one staff member who brought in a plate of food for another person. We saw they proceeded to give the person the food without telling them what the meal was or asking them if they were ready for their meal. We saw the staff member had mixed the contents of the meal together. We saw this staff member held the person's head back with their hand when giving them their meal which they did without any explanation of what they were about to do. The staff member told us they had to do this to get the food in. Yet when we looked in this person's care plan there was no evidence to support this. The care plan showed the person ate better when they were provided with finger foods and were to be offered pureed food if they did not eat the finger food. No finger food was offered to this person. We observed on several occasions this staff member referred to people as 'pet' and 'darling', whereas other staff called people by their name. Following the inspection the provider told us they had taken action to address these concerns.

We saw the same person being assisted with a meal by a different staff member on the second day and there was a noticeable difference. The staff member was kind and gentle taking time to explain what they were doing and encouraging them. We saw the person smiling in response and lifting their head for each mouthful.

During the morning on the first day of our inspection on the first floor a staff member brought in some giant dominoes to play a game with the three people who were sat in the lounge. The staff member placed the dominoes on the tables in front of these people but only asked one of the people if they wanted to play and did not explain what the game was. The staff member then proceeded to take the dominoes from each table and place them on the floor. We heard them asking two of the people if they had a three or a two but did not give them chance to reply and we heard one of them say, "What am I doing?" The other person said, "Don't rush so much." The staff member ignored them and the game was over very quickly. At the end the staff member announced who had won clapped their hands and then gathered all the dominoes up and put them away. During the course of the game they had not communicated at all with the third person. They

then said, "Let's see if we can put something on here" and tried to put on a DVD but were not able to change the channel so went to find the handy person who came and changed it. At no point were any of the people asked what they would like to watch. As the staff member was in and out of the lounge we heard one person say, "She rushing. I want to stop it."

Providers are required to take account of the protected characteristics set out in the Equalities Act 2010. We found there was an inconsistent approach to identifying and supporting people's cultural needs. For example, we found there were two people in the home whose first language was not English. In one case staff had learned some phrases which meant they could communicate with the person in their own language. However in the other person's case this had not been done and staff were not able to tell us with any certainty what the person's first language was.

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

Within people's care records we saw detailed personal histories which included information about their interests and preferences. This helped staff to develop an understanding of people's individual needs and preferences. This information helps staff to engage with people and can be particularly helpful when supporting people living with dementia.

Relatives told us there was a regular church service at the home for people who wished to attend. We saw activities to celebrate Christmas had been organised and included carol services and a Christmas party.

Although there was evidence of a key worker system, with everyone who lived at the home assigned both key and associate workers none of the people we spoke with could remember their key worker or recall being involved in their care planning. One person told us, "I don't have a key worker and I do not recall anyone talking to me about my care plans." Another person said, "I don't know if I have a key worker, I leave all the caring aspects to staff, they know what they are doing." A third person said, "I don't have a key worker."

In contrast most of the relatives we spoke with told us they were kept informed about any changes to their relatives care and support needs. One person said, "Generally [staff name] keeps me in the loop about what's happening with [person's name], she even informs me what [person's name] has for breakfast."

The home held meetings for people who lived in the home and their relatives called 'The Voice'. We saw the most recent had been on 28 November 2016 and was attended by five people with another person contributing by telephone. However, it wasn't clear from the records whether the people who attended were people who lived in the home or people's relatives. The meeting before that had taken place on 19 September 2016 and had been attended by nine people who used the service. It wasn't clear what arrangements had been made for people who didn't attend the meetings, for whatever reason, to have a say in how the service was run and to be kept informed about changes.

We saw people who used the service and their relatives were supported to consider and plan for end of life care. We saw the majority of people had DNACPR (Do not attempt cardio pulmonary resuscitation) forms in place. Information about DNACPR forms was recorded on a notice board in the office and on the daily handover record which meant it was easily accessible to staff in the event of an emergency.

Requires Improvement

Is the service responsive?

Our findings

Although we found some care records contained detailed information about people's care needs and preferences, they were not always accurate in reflecting people's current needs. For example, we saw one person's risk assessment showed they were at high risk of choking. The form stated any risk score marked with an asterix should trigger an immediate referral to the speech and language therapist (SALT) team and if the person had already been seen then they should be re-referred. The assessment dated 17 October 2016 showed the person had five scores which were asterixed, yet the last input from the SALT team had been in March 2016. This person's nutritional care plan was dated 7 January 2016 and provided conflicting information about their needs. For example, the care plan stated they drank normal fluids and did not require thickened fluids, yet staff we spoke with confirmed this person had thickened fluids. A handwritten entry on the care plan stated 'from 28/1/16 2 scoops/200mls' with no further explanation as to what this meant. This person's moving and handling assessment stated they required a hoist and small sling for transfers yet there mobility care plan review stated they required a medium sling.

Another person's nutritional care plan required updating as it stated they had one scoop of thickener to 200mls of fluid, yet a review in November 2016 showed two scoops of thickener to 200mls of fluid. This person's daily records in December 2016 reported pressure damage to their skin, yet there was nothing in the care plan to show how this was being treated.

We saw another person's wound care plan stated they required dressings to be changed 'every three days, maximum four days'. Yet we saw on one occasion the wound had not been redressed for eight days and was then found to be odorous and exuding, although it had improved subsequently. Similarly in another person's wound care plan we saw they had dressings to both legs which should be changed every five days. We found the dressing on one leg had not been changed for 18 days and there was a gap of eight days between dressings to the other leg.

One person who used the service told us they had dietary supplements which they took every night with supper. We looked at their nutrition care plan and found there was no mention of dietary supplements. We saw an entry in the care plan review section dated 25 May 2016 which stated the person had been prescribed supplements but the care plan had not been amended to include this information. In the same person's records we saw a short term care plan dated 18 April 2016 which stated the person was 'hypertensive'. The attached guidance stated short term care plans should be used for specific acute situations that are predicted to be resolved in a short period of time i.e. less than two weeks. The guidance also stated the care plan should be evaluated daily. The most recent evaluation was dated 27 November 2016, the one before that was 27 September 2016. The November evaluation stated the 'care plan continues.' The care plan stated the person's blood pressure should be monitored weekly and their GP be informed if it went up. However, there was no further information as to what the baseline was, what was acceptable or what should trigger a GP referral.

In another person's records their hygiene care plan stated they had two sets of dentures, top and bottom. However, in the person's bathroom we saw one set of dentures was still in the denture pot while the person

was in the dining room having breakfast. We asked one of the care staff about the person's dentures. They told us the person now only wore one set of dentures, they said they thought the person's dentures were now too big and hurt them. There was no evidence anything had been done to address this despite the fact the person had been assessed as being nutritionally at risk.

Although we saw a variety of activities were offered we found there was no evidence of individualised activities planned for people, predominantly on the first floor, who were cared for in bed. In addition, there was no clear evidence to show what activities this group of people had taken part in.

Most of the people we spoke with expressed the view there was not much activity in their daily routine. One person said, "I used to like dance, working with animals and motorbikes, but since I can't move out of bed, I am up to nothing much." Another person said, "Not a lot, just sitting around." A third person said, "I wish I could go out more instead of just watching telly and reading the newspaper every day."

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw some examples of good practice in responding to people's individual needs. For example, in the case of one person who needed some very specific support with one aspect of their care a pictorial care plan had been created to help make sure this aspect of the care was delivered consistently.

The home supports a local donkey sanctuary and on the first day of our inspection a donkey was brought to the home. A small number of people took part in this activity in one of the lounges on the ground floor and those that did evidently enjoyed the experience. However, we observed when the donkey left and staff started to serve lunch it was a relative who went around the room offering people the opportunity to clean their hands before they started their meal. This was discussed with the manager.

The complaints policy was displayed in the home. We reviewed the complaints log which recorded three complaints had been received this year. These showed the action that had been taken in response to the complaint and how the outcome had been communicated to the complainant.

One person who used the service told us, "I never needed to make a complaint, ever." Another person said, "If I was unhappy I would shout, I don't know the manager but I know a member of staff called [staff name]."

Two people's relatives told us they had raised concerns with the manager and were satisfied with how they had been dealt with.

Inadequate

Is the service well-led?

Our findings

The home has not had a registered manager since September 2013. The manager who was in post during this inspection had taken up their post in July 2016. They were in the process of applying to the Commission for registration following an application made on 3 November 2016.

The manager who was in post at the time of the last inspection in April 2016 had left the organisation. This high turnover of managers has been a feature of the service for the last three years. Many of the people we spoke with did not know who the manager was. One person said, "I don't know the manager but I guess I will let staff know about my concerns." Another person said, "I don't know who the manager is and I don't have any complaints."

Some of the relatives we spoke with did know who the manager was and said they found them approachable and responsive.

Two people's relatives told us they had raised concerns about the night staff and these had been dealt with by the manager. We asked the manager if they had carried out any night monitoring visits in response to these concerns. They told us they often started work early and worked late to see the night staff and monitor what was going on. They told us they did not keep any records of these monitoring visits.

The manager told us surveys had been sent out to people's relatives and friends in September 2016 and only five had been received back. We looked at these surveys and found although people had ticked boxes to show they were satisfied with the service, there were comments on four of the surveys which suggested areas where improvements could be made. For example comments included; "Find them (staff) polite and caring but seemed very rushed off their feet most of the time"; "Clean but laundry not returned to correct room. Clothes left in heap in bottom of wardrobe"; "Furniture has seen better days, rather shabby"; "Condition of furniture poor." Two of the surveys suggested there could be more social interaction for people and wanted more involvement in care plans. There was nothing to show what action had been taken in response to these comments. We saw the surveys had also singled out some named staff praising them for their helpfulness and their kind and caring attitude.

There were quality assurance process in place however as evidenced throughout this report these were not operating effectively. These are summarised as follows:-

People's medicines were not managed safely. Despite the fact that we found the provider in breach of this regulation at the last two inspections they had not taken effective action to make sure people's medicines were managed properly and safely as detailed in the safe section of this report.

During the feedback meeting at the end of the first day of our inspection we raised our concerns about the staffing levels on the first floor with the management team. They told us they had reviewed people's dependencies that morning and would be increasing the staffing levels on this floor. However, when we returned on the second day we found the staffing levels had not been increased. As on the first day we saw

staff were extremely busy and found the majority of people on the first floor were nursed in bed.

We found risks to people's health and safety were not effectively dealt with. As detailed in the safe section of this report this included risks arising from people's individual care and support needs and risks associated with the environment.

We found staff were not consistently receiving the training and support to carry out their roles effectively.

We found people's nutritional and hydration needs were not always being met as detailed in the effective section of this report.

We observed some poor staff interactions which compromised people's privacy and dignity. In addition we found the service did not have a consistent approach to supporting people with protected characteristics as defined by the Equalities Act.

We found that although some care records contained detailed information about people's care needs and preferences, they were not always accurate in reflecting people's current needs.

We found that although there was a programme of activities this was focussed on people who were more able and willing to take part in group activities. There were limited opportunities for people with more complex needs to take part in meaningful activity.

We found communication systems were not always effective. For example, on the second day of our inspection we saw an entry in the care plan of one person's room which stated all their tablets were to be crushed. We looked at the medication records and saw an entry which stated this instruction had been confirmed by the person's GP. We spoke to the nurse in charge who told us the person had capacity and had agreed to have their tablets crushed. We asked the nurse if they had contacted the pharmacist to check if it was safe to give the person's prescribed medicines in this way. They said they had not but would do so immediately. We looked in the person's care records and found an entry dated 15 December 2016, (five days before), which showed another one of the nursing staff had spoken with the pharmacist and confirmed it was safe to crush the medication. It was clear from the nurses response to our question that they were not aware of the information recorded in the person's records. This risked the person receiving inappropriate treatment.

On the first day of our inspection we asked for a print out of the call bell system in order to look at the response times to call bells. One of the management team tried to get this information for us but was unable to work out how the system worked. The information was eventually made available during the second day of our inspection. However, the format in which the reports were printed meant it was extremely difficult to check for any individual room what time the call bell had been activated and answered. This demonstrated the provider was not using this information to assess and monitor the quality of the services provided.

The area manager told us accident and incidents were audited and analysed monthly. These reports were sent to head office for review. We looked at the audits for September, October and November 2016. These listed the accidents and incidents and provided an analysis of the falls that had occurred. This included a comparison with the previous two months audits and showed actions to be put in place where people were falling frequently. The reports were well completed however we found some significant anomalies. For example, the falls audit for September did not include two falls that were recorded on the accident and incident log. We also found there was a lack of detail recorded to show what action had been taken in response to some accidents and incidents. For example, we saw on two occasions sensor mats had not

gone off when people had fallen because they had either not been switched on or were not in place. Yet there was nothing to show what action had been taken in response to this other than to remind staff. We saw one person's care records showed they had been found with a limb trapped between the bed rail and mattress which had caused 'redness' yet this accident was not included in the audit. We saw entries in one person's care records which described two different falls on 17 November 2016 yet these were not included in the audit or the accident records we reviewed.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.