Bupa Care Homes (BNH) Limited

Melford Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 7 and 19 October 2016 and the inspection was unannounced. Melford Court Care Home is a nursing home that provides accommodation and personal care for up to 52 older people. At the time of our inspection there were 25 people living at the service.

During our inspection the service was in transition between one manager leaving and another one taking up their post. The manager leaving had not made any application to become the registered with the Care Quality Commission (CQC). This meant that the provider had failed to register a manager for this service since 6 June 2014. A registered manager is a person who has registered with CQC 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.

During our inspection of the service in June 2015 we rated the service as Inadequate. During our last inspection on 4 February 2016 We found that the providers still needed to make improvements in the way the service managed people's medicines, ensured the nurses kept their clinical knowledge updated and in the way they monitored the quality of service they offered people. But overall we found that the service had made improvements in the quality of care offered to people and we rated the service as Requires Improvement.

During this inspection we found that this improvement had not always been maintained and further improvements were needed to ensure the service was meeting the fundamental standards.

There were not enough properly trained or skilled staff to support people safely and staff were not always clear about their roles for which they were employed. The service had a high dependency on agency staff, in particular agency nurses. There were only two permanent nurses employed, neither of whom worked at night. This meant people did not receive consistent care from staff who knew the care and treatment needs of the people they cared for.

Staff had received the training they needed to understand how to meet people's needs and what to do if they suspected someone may be being abused or harmed. They understood the importance of gaining consent from people before delivering their care. But where people were not able to give informed consent, staff and the manager did not always ensure their rights were protected.

Medicines were not managed properly or safely so that people received them as the prescriber intended. Audits of the medicines carried out by the provider did not always identify the shortfalls we had identified and action was not always taken to deal with these concerns to keep people safe.

People had enough to eat and drink to meet their needs. However, records kept to ensure that people who needed assistance to maintain their nutritional needs were not accurate or up to date.

People were not supported to express their views about the care they received or to be involved in making decisions about their care, they took no part in their care plan reviews. Staff treated people with warmth and compassion. They were respectful of people's privacy and dignity. Staff also made sure that people received support from healthcare professionals in response to the need for treatment and advice about their health and welfare if they became unwell.

People's opinions as to the quality of activities and entertainment they were offered was mixed. People who were mobile and able to take part in those activities offered said they were 'alright' but would like to be consulted in the planning with more activities based on their individual preferences. Those that were not mobile or stayed in their bedrooms did not receive similar levels of interaction as those people who were more active.

Outings and outside entertainment was offered to people. Care staff were limited to the support they could offer people in the way of activities because of their work load, especially at the weekend when there were no activity staff on duty and they were required to provide this level of support.

The service was not well led. Staff morale was low and people did not always receive care that was person centred. Quality assurance systems were not robust and action was not taken to address areas that were not meeting the requirements of the regulations.

During this inspection we identified a number of 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not always sufficient numbers of suitable staff on duty to keep people safe from harm and meet their care and treatment needs.

Nursing staff did not receive regular clinical supervision, support or on going appraisal.

Medicines were not managed or dispensed safely. Risks to people were not always managed in a way that protected them from harm.

Staff had received training with guidance in steps they should take to protect people from the risk of abuse and knew how to recognise signs that people may have been harmed and what action to take to report it.

Is the service effective?

Requires Improvement

The service is not effective.

Staff did not always have the knowledge and skills that they needed to be able to carry out their role in the service. Staff had received the mandatory training subjects, or training that is considered essential for staff in adult social care to have, but did not have access to other topics that were important for staff to know when working with older people, supporting people to live with diabetes and other medical conditions for examples.

People did not always receive care in line with legislation and national guidance in relation to the management of their medicines and with reference to the Mental Capacity Act 2005. For example, we found that one person was receiving covertly administered medicines although there was no evidence of any assessment of this person's best interest having been considered including a lack of consultation with the person's GP or relatives.

People were supported to eat and drink what they needed, but records that were meant to be kept so that the service could be sure that people at risk nutritionally were getting enough to eat

and drink were not being completed properly and were therefor ineffective.

People were supported to have access to healthcare services and professionals.

Is the service caring?

Requires Improvement

The service was not always caring of the people who used the service.

The care and nursing staff showed a caring attitude towards people they supported with their day to day living. But it was not evident that people and their families were involved in the reviews of their care.

While supporting people with their care needs staff protected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was responsive to their needs.

Care plans were not regularly reviewed to reflect people's changing needs. For example, prior to dressing changes for people with pressure ulcers.

There were systems in place for the service to learn from people's experiences and to listen to their complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not promote a positive culture, where people and staff felt confident that their private information or shared concerns would not be passed onto others or talked about openly.

The providers did have a quality assurance system in place, but it was not effective in identifying that not all levels of staff were trained to a sufficient standard or being supported in a way that enabled them to deliver a high quality of care to the people who used the service.

The provider's quality and safety audits did not identify the

shortfalls we found at this inspection. This meant they were ineffective at identifying and mitigating the risks to people's safety and wellbeing.

Melford Court Care 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.

The inspection took place on 7 and 19 October 2016, it was an unannounced inspection and took place in response to people's relatives and healthcare professionals who shared their concerns about the service with us.

The team who carried out this inspection consisted of three inspectors.

Before the inspection we reviewed the information we held about the service by looking at notifications received from the provider. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law. We also spoke with the local Authority who shared concerns that had also been raised with them.

Over the two days of our inspection we carried out observations and spoke with 13 people who used the service, six relatives, eight members of staff and the manager, their deputy manager. We also spoke with two healthcare professionals and one medical professional. During the inspection the manager was supported by the organisation's regional manager.

We reviewed ten people's care plans and care records. We looked at staff training, recruitment and support records for five members of staff. We also looked at the service's arrangements for the management of medicines and looked at 12 people's medicine records. We also looked at the complaints and compliments information, safeguarding alerts and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

During our previous inspection on 5 February 2016 we found the provider failed to meet regulatory requirements in relation to the management of people's medicines and nursing staff's lack of clinical knowledge. At this inspection we found that medicines continued not to be managed or dispensed safely.

We looked at 12 people's medication administration records (MAR) records and carried out an audit of stock of the medicines on the nursing and residential units alongside a nurse and senior carer. Firstly we noticed that the lighting in the clinic room upstairs was poor which could make it difficult for the staff to be able to see properly which may lead to mistakes.

We carried out stock checks on 12 items against records of administration. We found that, they did not tally. One person was prescribed 3mg and 2mg of Warfarin, we were unable to audit the 3mg as there was no record of stock carried forward and no record of amounts received. We audited the 2mg dosage of Warfarin, and found that there was 32 tablets unaccounted for. Several other items, including paracetamol for three people, could not be audited as there had been no record of medicines carried forward or stock received. This meant we could not be assured that people received their medicines as prescribed. Without maintaining an accurate record of medicines carried forward or stock received the provider would not be able to identify whether mistakes had been made or if medicines had gone missing.

We found that there were 12 too many of one person's Cetrizine, an antihistamine medicine. This indicated that staff may have signed for medicines but had not administered them. We found that stock did not tally for another person's Digoxin, a medicine prescribed for a heart condition. This meant we could not be sure people received their medicines as prescribed. This had not been identified in any of the management audits.

-Two people were prescribed transdermal patches to aid pain relief. Staff used a body map form entitled, 'record of application', to record where on the body the patch was applied so that a record was maintained to evidence a change to the position on each application as considered safe practice. This record had not been updated since 16 August 2016.

Medicines must be stored within a set temperature range; otherwise it is possible that their effectiveness would be detrimentally affected. To ensure medicines are stored safely, temperature checks must be done, records kept and action taken if the temperatures vary outside the expected range. We found gaps in records of the room and fridge temperature monitoring records. That meant that checks were not being consistently done, which could lead to people receiving medicines that were unsafe to use or ineffective.

Daily medicines audits to check the balance of stock against the MAR records had not been carried out in the last month in accordance with the provider's policy which recommended checks to be completed daily by nursing staff. Management monitoring audits had also not been completed as per Bupa policy. The latest monthly medicines audit carried out by the provider on 1 September 2016 showed that out of a possible score of 63, only 28 points were achieved, this was 44%, and there was a lack of evidence that the shortfalls identified had been addressed.

People's medicines were not managed or dispensed in a way that kept people safe from harm nor ensured that they received their medicines as prescribed.

This demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was not always enough staff on duty to care for people when they wanted or needed it or to help keep people safe. Nor had the needs assessment been used to calculate the necessary staffing levels.

We asked the deputy manager about the dependency level assessments and what action had been taken in regards to assessing people's needs, they said that they did not know anything about this area or how that information was used when preparing the rota. They said that they had not been shown how to do it and did not feel that was their responsibility as the deputy manager. However, they did take part in writing the rotas in the manager's absence and told us that they had made changes to the way the rotas were made up while the manager was away recently. This meant that the rotas were not completed taking into account the needs of the people who used the service and whether there would be sufficient staff to support those needs.

Gaps in the rota due to long term sickness or staff vacancies were filled with agency and bank staff. The high use of agency and bank staff to cover staff vacancies meant people were not provided with continuity of care by people who knew them well and knew how to meet their needs. There were only two permanent nursing staff employed at the service. Night nurses employed were all on long term sickness absence and there are a number of vacant nursing posts. This has resulted in a high use of agency staff for a prolonged period of time, especially at night.

Staff felt that the current staffing levels for care staff was sufficient to meet people's needs when the full allocation of staff are present. However, they also told us that the rota was not always managed effectively to ensure staff are allocated in a timely manner and they often work with less staff.

We reviewed the staffing rotas for the last six weeks and saw that there were occasions when staffing levels fell below the services agreed safe working limits. The deputy manager told us that the night time staffing should be one nursing staff and two care staff on the nursing unit and one senior care worker on the residential unit. However, on the night of the 27 and 30 August 2016 there was one nurse and one care worker on duty for the whole service. We also saw that there was a shortfall of staffing on the night of the 2 and 4 October 2016 when there was only one nursing staff and two care workers on duty across the home. Most of the people on the nursing unit required two staff to assist them with repositioning or personal care. This meant that at night whilst the nurse on duty administered medication and staff assisted someone on the nursing unit who required the assistance of two staff the remaining people on the unit were not monitored effectively to keep them safe and no staff would be available to support people living on the residential unit. This meant that people on both units did not always receive the care and support they needed to be safe and comfortable in a timely manner.

The rotas were not managed properly and gaps were not managed efficiently, staff told us that they would be left to the last minute and there was then a struggle to get cover. That meant that there were times when they had to work short of staff.

Staff told us that previously a clinical lead was employed on the top floor nursing unit and a care manager was employed for the residential unit downstairs. Both these posts had been removed by organisation in the last year. The impact of this has been that the nursing staff were now required to carry out the tasks these

posts had delegated responsibility for. These included the quality and safety audits, review and updating care plans, supporting staff with supervisions, appraisals and carrying out daily monitoring of care, including nursing support. However, nursing staff told us they had not been given designated time off the rota to enable them to achieve what was now expected of them.

On the second day of the inspection there were two staff on duty on the residential unit in the morning and only one member of staff rostered onto the late shift. Staff told us that there was one person on the residential who had been assessed as needing two staff members to assist them with moving in bed and who had been assessed as requiring a hoist for transfers. If they required assistance with personal care in the afternoon and into the evening, staff would have to request assistance from staff based on the nursing unit. Staff told us that at times this meant that the person would have to wait for their care needs to be met as the staff were busy helping others.

We observed that people who received care in bed received minimal contact from staff unless it was to carry out a task such as assisting with drinking, eating or personal care.

Some people had raised concerns that there were not enough staff to meet to their needs within a reasonable timeframe. People told us that staff could not respond quickly when they called for assistance using their call bells due to the current staffing levels. They told us they had waited for periods of 25 minutes and up to an hour for their requests for help to be met. People told us, "Staff will answer the call bells but tell you they are busy and will come back later." Another told us, "They are short staffed quite often. You can tell because there are not enough people about." Another person said, "They've got too much to do and they can't get to you." And another said, "If I ring for help, they come and say, 'I'm busy, I'll be back.' So I wait."

The process in place for the monitoring of the response to call bells was not effective and there was no evidence of the action that was taken when concerns had been raised. The maintenance person printed off the call bell times and highlighted any that showed that there had been a delay in response time. The deputy manager told us that they would then investigate as to whether the delay was caused by a system problem or by staffing. We saw evidence from the heads of department '10 at 10' meetings that the issue of call bells not being answered in a timely manner was raised on several occasions. It was raised on the 26, 27, 28 and 30 September 2016 for example, but there was no evidence what the concerns were or of what action had been taken to address the problem. People having to wait long periods for assistance could evidence that there were not enough staff on duty.

During our inspection we noted that it was usual practice for staff take their breaks in pairs, the breaks were also taken during people's mealtime. This meant that the remaining staff were stretched. The new manager told us that the provider's policy was that only one member of staff should take their breaks at any one time and that this had clearly not been managed appropriately.

On the first day of our inspection a staff member due to do a twelve hour shift, 7 -7 had phoned in sick. The deputy manager told us that they had intended to cover the early part of the shift and had asked for agency cover for the rest of the shift. There were not enough staff on duty to manage with one person down. The deputy manager said that this was a regular occurrence and it was expected that they themselves would cover shifts that were short of staff.

The deputy manager being required to cover unfilled shifts was further evidence that there were not enough care staff on duty to allow cover in emergency situations and short notice staff absence.

This also meant that they were not able to effectively carry out their role as deputy manager and support the

manager in his role. This was evidenced by a lack of staff supported with supervisions, appraisals and management audits within the service being completed.

Before our inspection we had received contact from people's relatives and staff members to share their concerns about staffing levels being insufficient. Despite what we had been told and our observations, staff on duty felt that there were enough staff available during the day to meet people's needs but that additional staff were needed at night.

If the service continues to admit people without a review of staffing posts allocated, staffing levels provided according to assessed needs, deployment of staff and a continued lack of clinical oversight people will be put at risk of harm from a lack of monitoring where risks have been identified and not having their care and treatment needs met.

The provider failed to ensure that there were always enough staff on duty to care for people when they wanted or needed it or to help keep people safe.

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

We looked at the recruitment files of five staff members. Safe recruitment and selection processes were followed. Files contained the relevant documentation required to enable the provider to make safe recruitment choices. Each file contained at least two references from previous employers, proof of identity and the relevant health checks for each member of staff. Prior to starting employment, new employees were also required to undergo a Disclosure and Barring Service (DBS) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

Records we saw showed that new members of staff completed an induction program. This consisted of a five day corporate induction followed by two days at the service during which staff observed staff providing care and were shown around the home and introduced to people living in the service.

Risks to people were not always properly assessed nor action taken to minimise risks to people in their environment. During the first day of our inspection we saw that a standalone oil fired heater was in use in one of the communal rooms. This style of heater generate so much heat that the surfaces become very hot and are not safe to be used without safeguards being put in place to stop people receiving serious burns if they came in contact with them. It was being used as a supplementary heating source because the radiators in that room was not working effectively, leaving the feeling room cold. However, risk assessments had not been carried out and it was placed close to an area where there were facilities for making refreshments that everyone had access to. The heater was removed on the day of the first inspection.

We also saw that the heated food trolley was in the dining room, it was turned on and the surfaces were very hot. We asked if the room was open to people to use when the trolley was on and not being supervised, we were told did. We pointed out the risks to people to the deputy manager and asked for risk assessment to be made and action to be taken to make sure people did not burn themselves. When we returned to the service we found that the risk assessment had been done the day before we arrived and it was handed over to staff on the heads of department '10 at 10' meeting on the morning of our inspection. There was no evidence that any action had been taken before then and people still had access to the room when the trolley was left unsupervised and turned on. That meant that people had been at risk of harm for 11 days after we had pointed out the risk and had asked for action to be taken.

There was no risk assessments in place for the use of any of the equipment listed above in the unsupervised proximity of the people who used the service.

This is a breach of Regulation 12(1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The call bell system was not set to sound throughout the building, staff held bleepers which indicated to them if people were calling for assistance. If staff were assisting a person in their bedroom and another person activated their call bell, they would not know that person needed assistance unless they were holding a bleep. There were not enough bleeps for each member of staff on duty to carry one, so, because staff tended to work in pairs, each pair carried one. The lack of sufficient numbers of call bell bleepers for each staff member on duty to carry one could put people at risk. If people needed help in an emergency situation for example and the staff member with the bleep was busy helping another person and could not go to their assistance.

When asked if there were any spare devices in case one broke, we were told that there were not. When asked what happened if one was broken or lost, we were told that staff walked the floor and checked people hourly. It would not have been possible to check everyone and keep people safe with the number of staff on duty as set out on the rota, especially on the residential unit, where there was often only one staff member based and who would have to request assistance from the team in the nursing unit if people were assessed as needing help from two staff members.

Risk assessments were in place to guide staff in the actions they should take to help keep people safe within their daily lives and with their personal care needs. We saw assessments for eating and drinking, bed rails, moving and handling and falls. Equipment was in place to reduce risks such as sensor mats to detect when people had left their bed and crash mats to protect people who were at risk of falling from their bed. We saw that moving and handling equipment was in place to support people to move safely. People who required the use of a hoist had this clearly documented in their care plans. On the residential unit assessments were regularly reviewed. Staff on the unit were knowledgeable about risks to people and worked in line with the assessments to make sure people remained safe. We saw that people who had the capacity to use them had call bells placed within reach.

Staff told us and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. They were able to demonstrate the action they would take and tell us who they would report concerns to in order to protect people. Staff understood the different types of abuse and knew how to recognise signs of harm and understood their responsibilities to report issues if they suspected harm or poor practice. They were confident that the manager would take action if they reported any concerns and were aware of the whistleblowing policy and said they would feel confident to use the process if they thought it was necessary.

One staff member told us, "I have done my SOVA [the Safeguarding of Vulnerable Adults] training. If I saw a staff member harming a resident I would report them to my team leader."

Requires Improvement

Is the service effective?

Our findings

Not all staff had the knowledge and support they needed to be effective in their roles. Nor had they been provided with the opportunity to access additional training to enable them to effectively support people.

On the first day of our inspection on 7 October 2016 the senior person in charge was the deputy manager. They were covering for the manager who was on two weeks leave. The manager's return was expected on 10 October 2016 and that would be their last week at the service as he had given his notice.

The deputy manager informed us that they had started work at the service first as a unit manager. Their role was to lead on the residential unit. They would do this by ordering medication, arranging appointments and carrying out care plan reviews for example. They had a Qualifications and Credit Framework (QCF) Level 3 in Health and Social Care.

Shortly afterwards they became the deputy manager. Considering that the service was a nursing home which provided to care to people with complex nursing needs and that there was a lack of clinical staff permanently employed, it was not apparent that they had the necessary management experience, training or qualifications to be able to carry out their role effectively.

The manager, who has since left, was often away from the service for personal reasons, which meant that the deputy manager spent much of their time managing the service in the manager's absence. The deputy manager was not clear what their role included and did not cover the manager's tasks when they were not at the service. To evidence this we saw that staff supervisions, appraisals and quality auditing audits had not been carried out.

The care plans were complex and it was not immediately evident what people's needs were. Agency staff would not have time to read people's care plans before they started their shift. This meant that people would be receiving inconsistent care from staff who did know them or had the required knowledge of what care and support they needed.

The deputy manager was not a clinician and would not be able to provide clinical supervision and guidance to the nursing staff. This is a concern because of the high use of agency nurses, particularly on night shifts, who would not be familiar with the service or the people who use the service, for example they would not be aware of the organisations policies and procedures and would not know where to find them. This put people at risk because there was not always a qualified person in a managerial position to monitor and oversee the clinical practice at the service. When the newly employed manager is absent the deputy would not be able to provide clinical supervision and guidance.

The deputy manager said they spend most of their time helping care staff. They also said that they had started working towards obtaining a management qualification, but because they were so busy they had stopped as they could not do both the training and their day to day work.

Throughout our inspection whenever we asked the deputy manager questions about the management of the service and their role they were unable to answer. We were not assured that they were sufficiently supported to act up in the manager's absence.

Staff told us that they had completed mandatory training such as fire, infection control and manual handling. However, they had not been supported to access additional training over the last twelve months. We found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage some aspects of clinical care. Clinical staff did not have access to training and supportive supervision to assist them in their clinical work.

We looked at staff training records which confirmed that whilst staff had completed their required mandatory training, they had not accessed additional training in areas such as dementia care or falls prevention which would have helped them to effectively meet the needs of people living in the service. Staff on the residential unit told me that recently they had been offered additional training in skin integrity and accountability; they described it as, "Very refreshing." to be offered training.

We found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage some aspects of clinical care. Clinical staff did not have access to training and supportive supervision to assist them in their clinical work. Staff told us that they had not had received regular supervision or annual appraisals and the deputy manager and regional support manager confirmed this.

The provider failed to ensure that all levels of staff had the training, knowledge and support necessary to their role This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This service did not always protect people's rights under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards,

People's consent to care was not always sought in line with legislation and guidance. Staff had attended Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals.

We saw one example where a decision may have been made without making sure that due process had been followed to ensure that it was a decision the person could not make for themselves or that it was made in the person's best interest. At the time of our inspection one person was being given covertly administered medicines. However, there was no evidence that a best interest assessment had been carried out or any evidence that the GP or relatives had been consulted.

There was little evidence in people's daily notes that they were asked for their consent for care procedures to be carried out in their day to day living.

The manager had an understanding of both the MCA and DoLS and when these should be applied to the people who used the service, including how to consider their capacity to make decisions. The service had made DoLS applications to the relevant bodies for the people who were restricted from leaving the service to protect their wellbeing. However, the last DoLS applications were made in September 2015, which meant that people who had moved into the service since that time may have been restricted from leaving the service did not have their rights protected under the MCA. The manager acknowledged that no MCA applications had been made in line with legislation and guidance to protect people's human rights. We were

reassured that action would be taken to rectify the situation.

This demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the food provided. People told us that they had a choice of what to eat every day and that if they did not like what was on the menu they were able to choose an alternative.

The service had sought specialist feedback in regard to some people's dietary needs, but did not always follow the guidance given or properly record people's food and fluid intake effectively as requested to do by the dietician.

Four people's daily food diaries reviewed on the first day of out inspection, we found gaps in the recording of the food people had consumed and also the monitoring of these diaries. There were also some duplicate records, which contained conflicting information. We gave feedback about these concerns at the end of the day to the provider to enable them to take action. However, on the second day of our inspection we found that there continued to be significant gaps in the recordings to evidence monitoring of people's at risk having received adequate nutrition and hydration to maintain good health.

We also found inconsistencies in the record of exactly what people had consumed with regards to their food intake. For example, one person staff had recorded on 6 October 2016 as having had for breakfast; scrambled egg, beans and tea. However, another record for the same day recorded Weetabix x 2 and toast. There was also duplicate records for another person, on the 6 October record one said Weetabix x 2. Record two stated scrambled egg and beans. Again on the 13 October 2016 record 1 4tsp scrambled egg and tea, Weetabix x 2 2tsp. Whereas Record 2 said scrambled egg and beans.

All of the food intake records we looked at contained gaps in the daily recordings or were not completed at all. The daily food diaries required a signature from the lead nurse to evidence their daily check of these records. None of the records we reviewed were found to have been signed as checked. This meant that because, these checks were not being carried out, they continued to be poorly recorded and were rendered ineffective as a monitoring tool.
The monitoring of people's weights was ineffective as they were not being consistently monitored. One person had not been weighed since August. Staff had tried to weigh them on the 29 September 2016 but the record stated that the scales were faulty. There was no evidence that staff had tried to weigh the person again, it had been recorded on the 'tracker' form that was on the notice board as a guide for staff to weight weekly but this had not been done. This meant that staff were not monitoring their weight to enable them to assess whether they were meeting their nutritional needs.

Another person received care from their bed and also needed staff to support them with eating. We found that no records of food or fluid consumed were kept. When asked staff told us that this person ate well. However, no weight had been recorded since April 2016. One record stated that the person did not want to be weighed as they found the hoist too painful to use and staff were instructed to measure the circumference around their arm to ascertain if their weight had decreased. It was evident that staff had not been monitoring this as stated as there were no records to support this. When asked, staff said these checks were not taking place as planned. This person appeared very thin, was immobile and stayed in bed all the time.

One relative told us that when visiting them in the afternoon they found their relative asleep with food in their mouth and their unfinished dinner plate in front of them. We referred this to the local authority

safeguarding team who have asked the service to investigate this concern and provide a response.

This service did not always monitor people effectively to ensure that they got the food and fluid intake to maintain a balanced diet, which is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff sat and supported people to eat in an unrushed and dignified way. We observed positive interaction between staff and the people they helped to eat their dinner. Staff sat with the person they supported, while chatting and encouraging them to eat.

Plate guards and specialist utensils were available for those who found it easier to eat with these aids. This helped to promote independence, meaning that people could manage to help themselves to eat without the need of staff support.

Records showed that people had access to healthcare professionals including the district nurse, GP, dentist and optician appointments. People were also supported to access specialist advice if necessary. This included the continence advisor, dietician and speech and language therapist.

Requires Improvement

Is the service caring?

Our findings

People told us that overall the staff showed a caring attitude towards them. Comments they made to us were mixed. One person said, "Some people are more compassionate than others." And another said, "Some of them are very poor." They went on to say that it depended who was on duty as to how good they were. Another person told us, "They are good people and try hard to help us, but they are rushed at times." Another told us, "I haven't been here that long and I wasn't sure if I was going to stay, but the staff are kind and care what happens to me." A staff member told us "It's a lovely home, it's a lovely environment." And another said, "It's like a family environment. We muddle along through together."

One person's care plan made several references to the fact that they enjoyed company and that when they felt lonely they became low in mood. However, when we spoke with staff they told us that the person was cared for in bed and therefore spent most of the time in their bedroom. We asked if the person was able to get out of bed and the staff told us that the person required a hoist to transfer tem from bed to chair, which they found uncomfortable and so they did not get out of bed regularly. We asked staff if the person had recently been assessed regarding their manual handling to see if there was solution to this problem such as a different sling size. Staff told us that the previous manager had assessed the person recently but there was no clear evidence of this in the persons care plan and the person had not been referred to an occupational therapist for specialist advice regarding their manual handling. This meant that they spent a lot of time alone in their room and not enjoying the company of others they had asked for.

Care plans contained a section called 'This is me', which were intended to contain information about people's life history and likes and dislikes. Some were quite detailed others less so. It was evident that people had been included when they were drawn up. However we did not see evidence that people had been included in their care plan reviews. The care plan format has a place for the person carrying out the review to sign it. There were also places for the person involved to sign it as well. Some of the care plans did not have either signature, but the people whose care plans they were had not signed them to indicate they were involved or agreed with the content. Meaning that we could not be confident that people were actively involved in making decisions about their care.

The service had a practice of nominating a person each day to be the 'Person of the Day'. On that day the person's care plan should be reviewed with the person involved and their family. Their bedroom would have a thorough clean out and generally they would be made to feel cared for and special. When asked the deputy manager told us that family were not told when their family member was the person of the day and were not invited to the review. During the inspection that the person of the day's care plan had been reviewed by a member of staff the previous night while they were on night duty. The person had not been involved. Neither was their room deep cleaned and the fact they were the person of the day acknowledged by the staff.

Interactions between staff and people who used the service were caring and appropriate to the situation. Staff demonstrated an understanding of how to meet people's needs. They spoke about people respectfully and behaved with empathy towards people. People's needs and preferences were understood and the

atmosphere was calm, staff engagement was positive and people and staff were comfortable in each other's company. The hairdresser was at the service and a staff member complimented one person on their hair and asked another if they wanted theirs done as well, there was some banter between the two people and the staff member during the conversation. Staff used people's preferred names including people who preferred to be addressed more formally.

People were treated with dignity and respect and staff were discreet when asking people if they needed support with personal care. One person told us, "They [the staff] try to make sure I don't get embarrassed, that's important to me." Another said, "They [the staff] check I'm alright, they're so kind." Any personal care was provided in private to maintain the person's dignity. We observed staff knocking on people's doors and waiting to be invited in before entering. Doors were closed during personal care tasks to protect people's dignity and we observed staff discreetly and sensitively asking people if they wished to use the toilet.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to the needs of the people who used the service.

Pressure areas were not always managed effectively enough to help speed their healing or to prevent their development. People who are frail and are unable to reposition themselves are at risk from developing pressure areas, or bed sores. This is because staying in one position for too long causes tissue damage and pressure ulcers to develop. We found that one person who had a high level pressure ulcer did not have a care plan in place to inform nursing staff how often the dressing should be changed. This meant that agency staff who may not be familiar with this person's care did not know how often it should be changed and with what dressing.

Neither did they have a pain management plan in place. We found a reference within their wound management care plan which stated; 'I would like to have morphine or paracetamol prior to dressing change'. However, we did not find any evidence within their daily records or where nurses would record changes of dressing that this person was ever offered this pain relief. Medicines Administration Records (MAR) charts evidenced that they had been administered Oramorph once daily. However, the pain relief was prescribed as being able to be administered up to four times daily if required.

When feeding back to the provider they told us this person would say if they were in pain. The fact remains that this medicine was not being offered prior to commencing a change of dressing to allow for the effect of pain relief time to work before staff commenced dressing changes. It would not be appropriate to wait until during the dressing change for the person to say they were in pain. If staff were offering this, they were not recording their actions.

Our concern about this person possibly being in pain while their dressings were being changed was fed back to the provider at the end of the first inspection day. On the second day of our inspection we found that, although their wound care assessment had been partially reviewed, no further action had been taken to assess the assessment of pain the person may experience when their dressings were changed or any evidence they were offered pain relief before the dressing was going to be changed. This meant that 12 days had passed and no action had been taken to protect this person from being in avoidable pain.

The same person's care plan stated they should be repositioned every two hours to avoid further tissue damage. However, the notice board within the nurse's office said four hourly turns. When we spoke with staff and asked which was correct they told us four hourly turns. We asked why the change was made. They told us that it was the provider's policy that people should be repositioned between four to six hours. The regional director was clear with us during feedback that the provider's policy was that individuals should be clinically assessed to determine how often they should be repositioned according to an assessment of risk. It was evident that the care plan had not been reviewed or updated and staff had not been provided with sufficient guidance. This put people at risk of developing pressure areas or of pressure areas getting worse if people already had them.

On the first day of our inspection we were told by a relative that their family member, who was cared for in their room, had 'Low moods and suicidal thoughts.' We saw that hourly observations were made, but staff told us this was due to them being cared for in their room. Their care plan did not contain a risk assessment about how this person should be supported to stay safe, but did say that they should not be left isolated in their room. Their relative told us that they liked the company of others and did not like to be left alone. On the second day of our inspection we saw that action had been taken to provide a risk assessment with guidance to staff on how to respond to the person's distressing requests for help to harm themselves. However, there was no evidence of any specialist, mental health support being accessed to provide a specialist view of how to support this person appropriately.

Daily care notes contained minimal information about the care people had received, comments included phrases such as, 'Personal care given.' and, 'Ate well.' The records did not describe effectively the care and support people had received and were not comprehensive enough for care staff to judge whether needs were met or if changes needed to be made to people's care plans.

These examples are evidence that the provider did not ensure that people's care clans comprehensively covered their assessed needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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-The time that activity staff spent with people was recorded individually within their care plans, therefore it was not possible to gain an oversight of how the activities co-ordinators spent their time and if it was fairly distributed amongst people.

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-The activities staff spent time during their working day serving drinks from the drinks trolley and assisting people at mealtimes. Whilst this is appreciated by the care staff and means that they have more time to carry out their tasks, it does meant that time that they could be providing group or individually planned activities is curtailed.

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-As with the care daily notes, the majority of the records where activity coordinators had been involved with individuals was minimal for example we saw records saying only, 'chatting', 'conversation'. There appeared to be a lack of organisation with no activities plan in place according to people's assessed individual needs, wishes or preferences.

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-The manager acknowledged that there was no quality of audit of the activities offered to people and that people were not involved in the planning of activities. There was no overall monitoring of the quality of activities provided at a management level.

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People and staff gave us mixed feedback about the activities on offer at the service. Staff said that some people had told them that they were bored at times. People who either could not, or did not want to attend the organised activities, had limited opportunities to engage in other interests. Some people were able to move around the home themselves and provide their own stimulation such as reading, listening to the radio, watching television and talking in each other's rooms.

However, we observed the communal rooms in the service were rarely used and that many people sat in their bedroom, with no meaningful interaction, stimulation or activity to keep them active and engaged.

-A high number of people upstairs receiving nursing care who had been described as not wanting to be left isolated in their rooms, liked the company of others. One person who often expressed suicidal thoughts was

also described as seeking the company of others. However, on both days of our inspection only two people were enabled to use the main communal lounge to be with others, the lounge was otherwise empty of people. A high percentage of people being cared for in the nursing unit were cared for in bed. It was not always evident the rationale for their staying in bed. When asked staff told us that some people did not like the use of the hoist but others they did not know why they stayed in bed. They described people who regularly used their call bell which they found frustrating. However, when questioned further as to what might be the root cause of their seeking attention they agreed this may be due to their being bored and looking for company.

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-There was no suitable specialist seating in the service to enable people who were nursed in bed to sit out of bed in their bedrooms or to spend time in the main lounges so that they could interact with others or to be engaged with the day to day activity in the communal areas if they chose to.

Individual staff members were kind and attentive to people. However, due to insufficient numbers of staff available, staff interaction with people was mostly when supporting people with care tasks.
The activities staff did not work at the weekend. The expectation was that care staff would provide activities for people at this time. However, staff told us that in addition to their day to day responsibilities it was not possible to provide meaningful activities for people. In addition to this, because activities staff were not in the service at the weekend it meant that staff were expected to cover this shortfall at the weekend, and take the drinks trolley around and had less staff available to assisted people at meal times. The rotas did not show additional staffing on a Saturday or Sunday to cover the shortfall in staffing that this created.

It was not evident that the service had properly assessed people's preferences in how they would like to be engaged in meaningful interactions, stimulation or activities to keep them active and engaged. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Outside entertainers visited the home regularly as did the Pets as Therapy (PAT) dogs. The people who were able to attend these entertainment sessions told us they enjoyed them. One told us, "I enjoy the distraction when we have people in to sing and entertain us." Another person, who had been taken out for a walk told us, "It was a bit chilly, but I enjoyed the fresh air."

We saw the same person having a game of carpet bowls with another person and one of the activity coordinators. Both people said that they enjoyed the game, one told us, "I like the challenge, I'll beat him [the staff] one day!"

The activities coordinators asked people to make a wish about what they would do if they could able to and then made plans to get that wish fulfilled. One person had wished to visit the Zoo. On the second day of our inspection they were taken on an individual trip to the Zoo.

Family and friends were invited to attend special events to celebrate special events such as the Queen's birthday, a harvest festival service and a vintage dress day for example. Local schools were involved in the service, PAT dogs visits were popular and church services were held to offer those that wanted it spiritual support.

Requires Improvement

Is the service well-led?

Our findings

Between the first day of our inspection and the second day the manager in post had left, they had already given notice of their intention to leave, and a six month interim manager had started two days before we returned to complete our inspection. Despite managers being recruited and reassurances being given that they would or were in the process of applying to be registered with the Care Quality Commission (CQC), there has been no registered manager in post since June 2014. This has meant that there has been no person in position that had been accountable to the CQC for their actions since that date.

During our previous inspection on 7 July 2016 we found that the provider's quality assurance systems were not robust enough to identify shortfalls and to drive continuous improvement, although we had found that there had been some improvements since the inspection prior to that. During this inspection we found that those improvements had not been maintained. This meant that there were no effective quality assurance systems in place to ensure that the quality of service offered to people was maintained to a high standard and that that standard was maintained.

Neither the manager nor the deputy manager had ensured that the quality assurance records had been kept up to date. We found gaps in monthly quality and safety monitoring which had not been completed since June 2016. The regional director carried out provider visits and feedback to the manager and any necessary actions were added to the service improvement plan. We were given the latest version of the improvement plan.

The actions identified included some of those we identified during our inspection. For example, shortfalls identified included all of the services' audits should be completed as per the organisation's planner with a comprehensive action plan being developed, care plans were to be reviewed, including risk assessments, concerns were to be documented to be followed up and any action taken was to be evidenced in people's care files and their daily notes. The start date for these actions was 1 June 2016. The improvement plan had not been updated since it had been produced and no action had been taken to meet the requirements despite the service being closely monitored by senior management.

Three days before the start of our inspection the provider carried out a thorough and comprehensive quality audit of the service. When we requested to view this report we were told the report would not be made available to us during the inspection as requested. It has since been provided to us. The provider's quality report also found that the appropriate action required to keep people safe had not been taken and confirmed the shortfalls we found at this inspection. The provider told us a new action plan would l be put in place and we have been assured that it will be implemented.

The deputy manager, did not have any management experience or training and did not work alongside the manager to support them as expected and set out in their job description.

The provider recognised that, because of personal reasons, the manager would often be absent from the service, they were not given any extra support. It was identified they were falling behind in their

responsibilities to monitor and audit the service during a provider's visits, but they were not given extra help to catch up. When asked what the organisation had done to support the manager, the regional director told us that, while they were aware that the manager was struggling to do their job, no extra support was put in place. For example no one that had management experience or training was put in to work alongside the manager to support and guide them during what was a difficult time for them. Nor was nursing or care staff properly supported to carry out their roles; one to one supervisions, appraisals and clinical reviews were not routinely carried out.

Staff described the lack of supervision. They described a culture of finger pointing and when supervision was carried out this was often not previously planned to enable them to prepare but that these meetings were used to give the staff member a 'telling off'. Staff meetings had taken place bi-monthly in the last year. Meeting minutes were brief with no descriptions of actions taken or follow up of issues raised by staff.

Communication within the service was not effective; communication books previously used by staff as well as handover information sheets had been removed in the last year. Staff told us this had impacted in a lack of information handed over to the next shift. This, as well as the high use of agency nurses who did not follow through on issues they raised with regards to people's care, meant changes in people's health conditions were not communicated when required. For example, request for guidance in response to a person who expressed the desire to take their own life and asked staff to help them, the repositioning of people at risk of acquiring pressure ulcers and changes in medicines.

The constant changes in management had clearly been very unsettling for staff who felt that new systems were continuously introduced and changed again before they had been given time to embed. This had created a culture in which some staff were sceptical about new processes that were implemented. This in turn had a negative impact on the care and support provided to people who live there. The staff felt that provider had not given the home proper oversight to ensure people were safe, and that staff had been managed appropriately.

Staff told us that morale was low. One staff member who had been working at the service for several years said they had seen at least 10 managers come and go during that time. This they told us it left them asking what hope was there for the service and would this new manager stay long enough to sustain any changes worthy of improving the lives of people who use the service.

The providers had not promoted a positive, inclusive culture within service and did not demonstrate or support good management or leadership skills. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people's care clans comprehensively covered their assessed needs. The service had not assessed people's preferences to ensure that they had the opportunity to participate in meaningful activities which kept them stimulated and engaged.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not made appropriate DoLS applications which meant that people did not have their rights protected under the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not safe in medication and care plans not always correct. Risks to people were not always properly assessed nor action taken to minimise risks to people in their environment. A standalone oil fired heater was in use in one of the communal rooms and the heated food trolley was left unsupervised in the dining room, it was turned on and the surfaces were very hot.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not always monitor people effectively to ensure that they got the food and fluid intake to maintain a balanced diet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that all levels of staff had the training, knowledge and support necessary to their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not enough staff on duty to care for people when they wanted or needed it or to help keep people safe.