Vishomil Limited

St Winifred's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 27 April 2017 and was unannounced. At the last inspection on 24 May 2016 we rated the service as Requires Improvement. We found three regulatory breaches which related to person-centred care, consent and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

St Winifred's Nursing Home provides personal and nursing care for up to 38 older people, some of who may be living with dementia. There were 32 people using the service when we visited. Accommodation is provided on two floors, there are single and shared rooms, some of which have en-suite facilities. There are a variety of lounge and dining areas throughout the home.

The home had a registered manager who commenced in post on 1 March 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present on both days of this inspection.

We found there were not enough staff on duty to keep people safe and meet their needs. People told us when they pressed their buzzers it was often a long wait before staff attended and we observed this happening.

Risks to people were not well managed which placed people at risk of harm or injury. For example, where people had been involved in incidents relating to equipment such as bed rails there had been no investigation into the incident or review of the risks to establish if using bed rails was suitable or safe. We also found environmental checks in place to ensure the safety of the premises in relation to hot water, radiators and window openings were not effective or thorough as they had not identified or addressed concerns we found at the inspection.

Staff had received training in safeguarding and understood the reporting systems, however we found safeguarding incidents were not always recognised or reported to the local authority safeguarding team. For example, we found one person had an extensive area of unexplained bruising, yet this had not been referred to safeguarding and no action had been taken to investigate the possible cause.

Medicines management was not always safe which meant people were at risk of not receiving their medicines when they needed them.

Safe recruitment processes were in place and staff received induction and ongoing training. Systems were in place for staff appraisals however there were no systems in place to ensure staff received regular and meaningful supervision.

Staff lacked understanding of the legislative requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's care records were not accurate or up-to-date and did not reflect people's needs or preferences. Complaints were not investigated in accordance with the provider's own complaints procedure.

An activity coordinator worked 20 hours a week and we saw some people enjoyed a singalong with a visiting entertainer. However, people told us they felt more could be done to fill their days and also wanted opportunities to go out.

People told us they enjoyed the food and we saw people were supplied with drinks and snacks between meals. People had access to healthcare services such as GPs and other specialists.

People praised the staff and we observed some kind and caring interactions between staff and people who used the service. However, we also saw occasions where staff did not respond in a compassionate way when a person needed assistance.

We found there was a lack of consistent and effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. This was evidenced by the continued breaches we found at this inspection. Following the inspection we made a number of safeguarding referrals to the local authority safeguarding team.

We found shortfalls in the care and service provided to people. We identified seven breaches in regulations – staffing, safe care and treatment, safeguarding, dignity and respect, person-centred care, consent, complaints and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

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.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment checks were completed before new staff started work to ensure their suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were not always recognised, dealt with and reported appropriately.

Is the service effective?

Inadequate

The service was not effective.

Staff received induction and training, however there were not effective arrangements in place to ensure they received regular supervision.

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us most of the staff were kind and caring and this was mainly confirmed through our observations. However, we found some people's choices were limited and saw isolated incidents where staff did not respond in a caring and considerate way when people needed assistance.

Care plans contained some personalisation which helped staff get to know the people they supported.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not accurate or up to date and did not reflect people's preferences.

People told us activities were limited. Although people's interests and hobbies were recorded this information was not used to support people in meeting their social care needs

Complaints were not recorded and dealt with in accordance with the provider's complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not consistent or effective. Processes in place to assess, monitor and mitigate risks to people's health, safety and wellbeing were not effective.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service and regulatory breaches identified at the previous inspection had not been met.

St Winifred's 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 25 and 27 April 2017 and was unannounced. On the first day of the inspection there were two inspectors and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day two inspectors attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We did not ask the provider to complete a Provider Information Return (PIR) as they had completed one before our last inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed how care and support was provided to people. We spoke with seven people who were living in the home, five visitors, two nurses, a senior care worker, a care worker, the chef, the maintenance person, the deputy manager and the registered manager.

We looked at eleven people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We found there were not effective systems in place to assess, monitor and manage risks to people and keep them safe. Our review of care records showed recent incidents with four people related to the use of bed rails, two of which had resulted in an injury. We looked at the bed rails in use for these four people and identified a number of concerns. For example, bed rails fitted to one person's bed were not appropriate for the type of bed the person was using and had not been fitted correctly. Bed rails on another bed had not been secured properly. We saw bed rail bumpers were in use however these did not always cover the full length of the rail. This meant people were at risk of injury or entrapment from the parts of the rail which were not protected by the bumper. Incident reports we saw showed people had been found with their legs through the bed rails. Although risk assessments were in place we found these had not been reviewed or updated following incidents to consider whether the continued use of bed rails was safe or appropriate. We raised these issues with the registered manager on the first day of our inspection and they ordered new beds and bed rail equipment to be delivered.

We saw another accident report from February 2017 which showed a person had sustained an injury when a piece of equipment they were using had collapsed. There was not a full account of what had happened and there had been no investigation into the incident. Although the equipment involved was removed following the incident, there had been no action taken to review other similar equipment in use in the home to ensure it was safe. These checks have now been put in place after we raised this with the registered manager.

We found risks around hot surface temperatures had not been identified or mitigated. We saw radiators affixed to bedroom walls and in corridors which were unguarded and did not have low surface temperatures. On the first day of our inspection we found some of these radiators were on full and when we touched the surface of them they were so hot we could not keep our hand in contact with them. This meant if people fell against them they were at risk of sustaining burns. We raised this with the registered manager and when we returned on the second day the temperature of the radiators in the corridor had been turned down. However, we found there had been no review of the other radiators, one of which remained very hot to touch. We reiterated to the registered manager the need for this to be addressed promptly.

We found window restrictors were in place on some but not all of the windows above ground floor level. This put people at risk of falls from windows which could be fully opened. We reported this to the registered manager who took action to ensure restrictors were put in place.

We saw care plans contained assessments of risks associated with people's care and treatment, including falls, skin integrity, nutrition and oral health. Although risks were identified there was a lack of guidance for staff to show how these risks could be minimised. For example, in one person's care plan for maintaining a safe environment there was a statement, 'I have a history of falls,' however there was no information relating to how staff could reduce the risk of the person falling, or activities which may increase that risk. Care plans included a list of 'Things to consider' related to risks, however these were generic lists which had not been personalised to give meaningful guidance. For example, the list attached to one person's risk assessment for skin integrity included 'Preferred time of going to bed,' 'Enjoys/prefers baths/showers,' and 'Liable to

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

On the first day of the inspection we noted variations in the temperature in different areas of the building with some areas noticeably colder than others. One person in the dining room kept saying how cold they were and when we brought this to staff's attention they brought the person a blanket. We mentioned the differences in temperature to the registered manager who raised it with the maintenance person and by the afternoon all areas of the home felt warm. We checked the hot water temperatures and found the water was only lukewarm at some taps and very hot at others. Staff told us there had not always been a supply of hot water to all rooms and two staff told us they had to get hot water from the sluice room. One staff member said, "A couple of rooms didn't have hot water, but this has been fixed now. We have bowls, and we had to get hot water from the sluice."

We saw certificates showing fire systems and equipment, electrical systems, gas installations and lifting equipment were tested to ensure their safety at appropriate intervals. In addition the provider had records to show regular safety checks were carried out in areas such as water temperatures, bed rail equipment and fire precautions. However, we found where issues had been identified prompt action had not always been taken to resolve the problem. For example, monthly records of water temperature checks identified problems with the hot water dating back to August 2016 and each month recorded that quotes were awaited from a plumber. Similarly weekly maintenance checks of bed rails had been recorded yet we questioned the thoroughness of these checks as none of the issues we found during the inspection had been identified through these checks or resolved. We saw environmental risk assessments had been completed but found these did not cover some areas of risk we found, such as the railings at the top of some flights of stairs which were at a height where people could easily lean over and offered no protection to prevent people from falling down onto the stairway. We highlighted this as a priority to the registered manager.

We found issues identified at the last inspection in May 2016, which the provider had told us would be addressed in the near future, had not been addressed. These related to corridor carpets which did not fit to the edges on the lower ground floor and floor boards in corridors which made a very loud noise when people walked on them. We found these remained unchanged. We identified numerous minor maintenance works such as no shades on light bulbs in ensuite toilets, screws left protruding from walls where pictures or fittings had been removed, broken window latches, broken door handles and over bed lights which were not accessible to people when they were in bed. We found a kitchenette where staff and visitors could make drinks was in a poor state of repair with damaged worktop surfaces which meant surfaces could not be cleaned properly or kept hygienic. This was a breach of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found systems and processes in place to manage medicines were not always safe or effective.The nurses told us the administration of prescribed nutritional supplements and thickening agents had been delegated to care staff. We saw these products were kept in an unlocked cupboard near the kitchen. There were two sets of medication administration records (MAR) for these supplements. One set of MARs was held in the nurses' file and included the prescribed supplements but had no signatures to show these had been administered and directed staff to separate MARs kept in a dining room file. We looked at these MARs and found they were incomplete and did not always reflect the supplements prescribed. For example, one person's MAR kept in the nurses files showed they were prescribed two nutritional supplements yet the MAR kept in the dining room files named only one supplement. We spoke with care staff who administered these supplements; they told us care staff only signed the MAR to state they had given the person the supplement and did not stay with the person to make sure they took it.

The nurse told us one person received their medicines covertly (hidden in food or drink). They said the person's medicines were in liquid form and were mixed with a prescribed nutritional supplement before being given to the person. We looked at this person MAR and found there was no information on or with the MAR to show this was how the person's medicines were administered. We saw a letter from the person's GP dated 27 September 2016 which stated they were happy for the person's medicines to be given to them in fluids as long as the person agreed and if the person did not agree then this would need to be reviewed. The nurse told us they did not tell the person their medicines were hidden in the nutritional supplement as if they did the person would not take them.

We saw some people were prescribed 'as required' medicines and we saw there were protocols in place to guide staff as to when these medicines should be given. However, we found staff were not recording the exact time of administration which meant with medicines such as pain relief, which required a minimum time gap between doses, staff were not able to determine if there had been a sufficient gap before administering the next dose.

The application of creams was delegated to care staff who were delivering direct care and creams were stored in people's bedrooms. We found the completion of topical medicine administration records (TMARs) varied. We saw some records were well completed with body maps showing where the creams should be applied and TMARs signed by staff to show the cream had been applied. In contrast other TMARs and body maps were incomplete.

We saw blood sugar monitoring equipment, which included lancets used to pierce the skin, was not stored securely. This posed a risk as it meant this equipment could be accessed by unauthorised people.

We checked the stock levels of two people's boxed medicines with the nurse and found discrepancies as the stock levels stated on the MARs did not match the medicines we counted. While we were with the nurse they looked through the stock kept in cupboards as well as those in the medicine trolley yet we could not reconcile the stock balance. We informed the registered manager who carried out their own count. They told us some of the medicines had been set aside to be returned to the pharmacist and if these were included the stock count was correct. They said the stock balances on the MAR were only updated weekly to reflect any returned medicines so therefore the balances were incorrect.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs (CD). There was an inner cupboard within the medicine cupboard for storing CDs, however the nurse told us this cupboard was not big enough to store all the CDs. We saw some CDs were stored outside the inner cupboard. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All other medicines were stored securely and the temperatures of the storage areas, including the medicines fridges, were checked to make sure they were within the recommended limits. We observed the nurses administering medicines and saw they were patient and kind with people. The nurse supported and stayed with each person to make sure they had taken their medicines. We heard them ask people if they required any pain relief.

Our observations and feedback from people who lived in the home, relatives and staff indicated there were insufficient staff deployed to meet people's needs. The registered manager told us they rarely used agency staff. However, people we spoke with commented about the use of agency staff and told us they often had to wait when they needed assistance from staff. Comments included: "I think they are still struggling with staff, a few nights in a week we usually have agency staff." "There is a shortage of staff. Staff response to my

buzzer is always delayed. We have agency staff helping us at night and during the weekend, they don't work like regular staff who have some idea about how I prefer things to be done." "They could do with more staff, because I've got (medical condition) and I can't do most things for myself. It sometimes bothers me that our buzzers are not being responded to quickly enough, usually when I want to go to the toilet" "They could do with more staff, when I press the buzzer to go to the toilet, I have to wait up to 30 minutes before someone comes to help me." "When I press the buzzer, even though it may take a long time before staff respond, they do come eventually. Their famous excuse being that there are other residents who have more needs than me and therefore require more support than me."

A relative told us, "There is never enough staff to take them on trips, I have seen a few agency staff and each time I worry on behalf of residents as it is best to be looked after by regular staff, more accountability, more familiar face."

Staff we spoke with said there were not always enough staff on duty. One member of staff told us, "Sometimes we can't answer the call bells in time. We have to prioritise who we go to first. If one resident buzzes whilst you are dealing with another, we have to cancel their call bell to deal with the emergencies first."

We saw some people were sat in the different communal areas throughout the home whereas others chose to stay in their rooms. We observed there were periods of time when there were no staff present in the communal areas and we had to locate staff to provide assistance to people. The handover sheet for one person stated staff were 'to not leave out of sight' during the day, yet we saw on several occasions this person was in a communal area where no staff were present. We were with another person in their room when they pressed the call bell for staff and it took five minutes for staff to respond. A further person we spoke with told us staff were not always able to respond to their call bell in a timely way. They told us they used the call bell when they needed assistance to move from their chair to the toilet, and said, when staff did not respond in time, "I just have to let it all go wherever I am sat." On another occasion we pressed the call bell for a person in their room, there was no response and we had to go and find staff to assist the person. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were in place. We looked at the recruitment records of three staff, which showed appropriate background and identity checks had been carried out. These included contacting former employers for references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people.

Staff we spoke with were aware of the safeguarding procedures and were able to describe the different types of abuse which may occur. Staff told us they would report any concerns about people to the registered manager and were confident these would be dealt with appropriately. However, although the provider's whistleblowing procedures were displayed in the home, not all staff were of these or knew which external bodies to refer concerns to, such as the Care Quality Commission.

We also found there was a lack of consistency in identifying abuse and following safeguarding procedures. Although we saw some safeguarding incidents had been identified and referred to the local authority safeguarding team, we found others had not. For example, we saw photographs which showed extensive, unexplained bruising to one person. This had not been recognised as a safeguarding incident and was only reported to the local authority safeguarding team when we advised the registered manager to do so. Similarly incidents related to bed rails and other equipment had not been identified as safeguarding,

although we made safeguarding referrals about these incidents following the inspection. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw supplies of personal protective equipment such as gloves and aprons were available and saw these were used by staff appropriately. However, we identified concerns in respect of other infection control matters. For example, on both days of the inspection we saw one person's catheter night bag in their room and the valve which connected the night bag to the day bag was uncapped and touching the floor. This presented a risk of infection being introduced when the bags were connected. We saw a recent entry in this person's daily records which stated staff had taken the night bag off and 'rinsed it'. We raised this with the registered manager who was not aware of this entry and told us this should not have happened.

Inadequate

Is the service effective?

Our findings

At our last inspection we identified concerns relating to consent, in particular around the management of conditions applied to Deprivation of Liberty Safeguards (DoLS) authorisations. We found similar concerns at this inspection.

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 so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some DoLS had been authorised with conditions the provider had to meet. For example, one person's DoLS conditions included the need to review documentation relating to the person's covert medication documentation to ensure it was compliant with the MCA. We saw the documentation review consisted of a handwritten amendment on the original best interests document stating 'Reviewed 10.1.17'. We found the person was no longer receiving covert medicines.

Our discussions with staff showed a lack of understanding about DoLS. One staff member told us, "People have a DoLS where they can't think for themselves, you need to make decisions for them." We asked if they would prevent anyone from leaving the home unaccompanied if they indicated they wished to do so. They told us, "It depends on people's capacity whether or not they can go out by themselves." When we asked another staff member if they knew about the MCA and DoLS they said, "I haven't done any training in it but I know (Name of person) has got one as they don't want to go to the toilet but we can take them as they've got a DoLS in place."

We saw mental capacity assessments in some of the care records we reviewed however these demonstrated a lack of understanding of the principles of the MCA as they were not decision specific. For example, we saw one person's MCA assessment considered the person's capacity in relation to personal care, treatment, medicines, nutrition and equipment usage. The assessment concluded the person lacked capacity in all these areas, yet the MAR for this person contradicted this as it had been ticked to state they had capacity in relation to medicines. There was no evidence to show how decisions had or would be made in the person's best interests. Similarly, another person's care records showed they had bed rails and a sensor mat in place yet there were no capacity assessments or best interest decisions documented in relation to these restrictions. Some care plans we looked at contained records of best interests decisions which referred to consultation with the person's family, however this was not always the case. Another care plan we looked at contained no records of best interest decisions having been made. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had worked to improve supervision and appraisal for staff, however we found there was no meaningful process in place to ensure staff had regular opportunities to discuss their performance and development with a line manager. A 'Skills Matrix and Supervision' form was completed with observations against a number of criteria including effective communication, team work, health and safety and nursing and personal cares. These observations were not signed by the employee to show the findings had been discussed with them. The registered manager told us, "We use the observations in the appraisal. We haven't sat with staff and gone through them."

Some observations did not evidence a robust approach to ensuring staff remained competent in their role. For example, we saw two instances where observations to evidence 'medicines' supervision were listed as observing the nurse making a phone call to order prescriptions. Another supervision referred to a nurse shadowing a colleague to refresh their knowledge following a medicines error. The supervision stated this would continue, 'Until the manager returns from leave.' There was no evidence this had been reviewed by the registered manager. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff induction records we reviewed showed there were regular observations of staff practice, evidencing their development and on-going suitability for their role. These records were signed by the employee to show they had participated in the discussions and agreed with any comments. The induction record for one recently recruited staff member consisted of undated observations including those related to nursing and personal care, effective communication, medicines, and legislation.

Staff we spoke with told us they received regular training, some of it face-to-face and some online. They said the training was kept up to date. The registered manager provided us with a training matrix which showed staff were up to date with training the provider had identified as mandatory. This included areas such as moving and handling, fire safety, safeguarding and infection control.

We saw some examples of an annual appraisal taking place with staff. We saw this recorded an overview of the previous six months, and covered areas such as timekeeping, attitude to work, patient care, strengths and weaknesses, training and development and future aspirations. We saw the records were signed by the staff member.

Most people told us they liked the food, although some commented on the lack of variation in the meals. Comments included: "I am well fed, even though there seems to be the same food choices, there are options." "There was something I fancied and they brought the cook to speak to me but nothing's changed since." "There is always something to eat, if I don't like something such as beans, staff always give me something else." "The food is good, though it could do with alternating. Sometimes I find I get hungry at night, I ask staff for something to drink, but because they are too busy, it takes a while – I have now resorted to saving some of my tea or supper in case I get hungry at night." "Food is great, more food, more choice."

We spoke with the cook about arrangements to meet people's nutrition and hydration needs. They told us there was a six week rolling menu in place, with choices for each meal. The cook told us people could ask for an alternative if the menu items were not to their taste. We found there was a range of fresh ingredients in stock, and the cook told us the kitchen manager was able to order whatever was required. Meals were routinely fortified with ingredients such as butter and cream, and adaptations were made to ensure people were not given foods they could not eat. For example, puddings were adapted to make sure they were suitable for people with diabetes. The cook told us the nurse on duty updated them each day about other dietary needs, such as pureed or soft foods needed by people at risk of choking.

We observed lunch on the first day of the inspection and there was a calm and pleasant atmosphere. The menu choices were displayed on the notice board. We saw staff supported people with their meals prompting and encourage them. The food was well presented and feedback from people about the meal was positive. We saw people were provided with drinks and biscuits throughout the day.

Care plans we reviewed showed people were supported to access a range of health and social care professionals where needed. This included GPs, opticians, tissue viability nurses and district nurses.

Requires Improvement

Is the service caring?

Our findings

People we spoke with described staff as respectful, caring and compassionate: One person said, "Staff are very good, they do their job very well" Another person commented, "Staff are caring and pleasant despite them being under pressure with jobs they have to do, it is very difficult for them" A further person told us, "Staff seem to be very respectful, most of them are willing to help and do anything for you." Another person said, "Staff are very nice people, sometimes I think it depends on the kind of pressure they are under, they've got lots of residents to look after." One person said, "Staff are tip top for me."

Visitors also praised the staff. One visitor said "Staff are very approachable, just busy, the male nurses are more gentle than most." Another visitor told us, "Staff have a lovely attitude towards us, they are very open and receptive" Another visitor said, "I'm impressed with the care here."

Most people told us they were able to make choices about their daily lives. One person said, "I am quite happy, I am sat in my chair now but if I wanted to go to bed this afternoon, they'd let me." Another person said, "I tell staff when I want to go to bed or get out of bed." A visitor said, "I have been in the room when they asked my relative what clothes she wants to wear, and I think that's brill."

However, others described limitations around choices. One person told us, "I have a bath once a week, staff give it to me, it is not my choice. I am ok with it though, simply because it is normally cold in there (in the bathroom). My main concerns are toileting and having to wait to go bed till late even though I am woken up at 6am by night staff." Another person said, "I decide when to have a bath, which is not very often as the water is never warm enough, staff tell me there is something wrong with the boiler."

The majority of interactions we observed between staff and people who used the service were kind, caring and gentle. We saw staff bent down to talk to people so they were on the same level and reassured people when they were anxious or upset.

We saw staff maintained people's privacy and dignity by knocking on doors before entering and ensured any personal care was carried out in private. People were supported by staff to ensure they were well groomed and comfortably dressed. We saw staff were discreet when discussing personal care needs with people in public areas, and spoke to people in friendly and relaxed tones.

However, we saw some isolated incidents where staff were not caring or considerate in the way they responded to people. For example, on the first day of our inspection, we were in the dining room in the morning and it was cold. We heard one person repeatedly saying, "It isn't fair that we should be so cold. It's very cold in here, very cold." Although several staff members came in and out of the dining room while the person was saying this no one took any action until we asked a staff member if they could help the person, which they did by bringing them a blanket. However, the person remained cold and could be heard saying, "Please god make us a bit warmer." Again no staff responded until we asked a staff member if the person could be taken somewhere warmer and then staff asked the person if they would like to go into the lounge and took them there. We saw the person a short while later in the lounge and asked them if they were

warmer and they said they were. On the second day of the inspection, we heard the same person ask two different staff members to take them to the toilet. One staff member said they would take the person after they had had handover. Another staff member ignored the request and instead took the person to the dining table and asked them to eat their breakfast. When we asked this staff member why they hadn't taken the person to the toilet as they had asked, the staff member told us they had finished their shift. We asked them to find staff to assist the person and 15 minutes after the person had originally asked to go to the toilet they were taken.

We looked at records which showed when people had had baths or showers. Our review showed people frequently went for periods of up to three weeks without having a bath or shower. For example, we saw two people had not had baths or showers for over three weeks in January 2017.

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

Care plans contained information which staff could refer to that helped build meaningful relationships with people. This included a 'pen picture' of the person, information about important friendships and relationships, hobbies and preferences such as favourite clothing and hair styles.

Inadequate

Is the service responsive?

Our findings

At our previous inspection we found people's care plans were not always up to date or accurate and there was a lack of meaningful activities for people. At this inspection, we identified similar concerns.

The registered manager told us the new care documentation which was being implemented at the last inspection was now in place and all the care plans had been re-written. Our review of the care plans showed people's needs had been assessed before they were admitted to the home. We saw care plans were in place for all aspects of care however, these were not always up to date or accurate. For example, we saw one person's nutritional care plan was dated 14 June 2016 and although additional entries had been made in November 2016 and February 2017 the care plan did not reflect advice given by the dietician in April 2017 regarding nutritional supplements and fortified diet. Another person's care records showed they had sustained a skin tear on 23 April 2017 which required a dressing, however there was no reference to this in the person's care plans.

There was not always a robust approach to the management of behaviours that challenged the service. For example, we observed an incident during our inspection where a person had become very aggressive with a member of staff. We saw the person's care plan was updated, however there was no guidance for staff to indicate how they could work in ways which minimised the person's risk of exhibiting behaviours that challenge, and no evidence incidents were being monitored in ways which would have enabled the service to understand more about triggers and strategies for ensuring the person and staff remained safe. The deputy manager told us, "We do not use ABC charts. We use behavioural monitoring charts where needed, and these would be kept in the person's file." We did not see any evidence of these charts in the person's file.

We found inconsistencies and gaps in information about monitoring people's health care needs in relation to diabetes. For example, we saw one person's care plan stated their blood sugars were to be monitored daily and if they were too high or too low the GP was to be informed. However there was no information to show what the normal blood sugar level was for this person, although the handover sheet stated if the person's blood sugars dropped below 5mmols the GP was to be informed. This was not stated in the care plan. We looked at the blood sugar monitoring charts for this person and saw their blood sugar had been tested four times in March and twice in April 2017. We saw the care plan for another person with diabetes stated their blood sugars were to be monitored daily, yet when we asked one of the senior nurses they told us the person's blood sugars were checked weekly. There was no information in the care plan to show what normal readings were for this person. The blood sugar monitoring chart showed their blood sugar had last been tested on 18 April 2017. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the activities co-ordinator who also worked as a senior care staff member. They told us since July 2016 they worked 20 hours a week on activities. They said activities included dominoes, singalongs, racing games and news reading for groups and small chats with individuals in their rooms. There were no planned activities displayed on the noticeboard although staff told us, "Even though there is nothing on paper for the week, everyone knows that there will be a church service and pampering occurring weekly."

The activity co-ordinator said, "We have entertainment every other week, I like to be spontaneous and at the moment it is about getting to know residents, some need a little or more encouragement, it is getting them motivated which is a biggie, as most days are demanding. To be honest 20 hours is not enough to do everything in activities, we are not doing any trips as we are waiting for support from the local authority before we can look at places to take residents to, and even then we will need more staff or volunteers to support the trips."

On the first day of the inspection an entertainer was singing in the downstairs lounge. Fourteen people attended the session and we saw the activity co-ordinator was singing and encouraging people to clap, wave and stamp their feet. Some people joined in playing tambourines and other percussion instruments and others were singing along. There was fun and laughter as the entertainer was engaging and joking with people. One person said, "Take a bow Mr Singer, you have done a good job." Another person said, "It is good banter. We love the artist, he is jocular."

Some people we spoke with said they joined in with activities, but most felt that more could be done to fill their days. Comments included; "I like it when we have music and karaoke, but wish we could go out on trips as well" "I used to do some knitting before, now I spend most of my time in my room, I wish I could do more even though I don't see very well, the most I go to is hospital or my son will take me out sometimes." "We don't go outside, I am just waiting to go home." "Staff leave me alone most of the time, I put the telly on and listen to my radio." "When the weather permits staff take me out to the garden."

Relatives made similar comments. One relative said, "There is not much going on for residents." Another told us, "There are no trips, as a result they don't go outside, not unless I take my relative out myself." A further relative said, "Sometimes staff do offer that we can join one or other activities in the lounge, but my (relative) can't because of (medical condition), we buy her some of her favourite magazines and staff read them to her."

Activity records we reviewed showed there were few meaningful activities taking place for some people. For example, one person's activity sheet showed they had participated in only two activities in March 2017 which were a hand massage and a friend visiting. Fourteen other entries for the month stated the person was 'sleeping'. In another person's care records we saw staff had recorded 'Sleeping' as an activity on 12 days in one month. In a third person's care plan we saw it was important to the person they attended the church services in the home. There was no evidence in their activity records that this had happened. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who lived in the home and visitors if they knew how to make a complaint and received a mixed response. Some people told us if they had any concerns they would raise them with staff and one visitor told us a complaint they had raised had been addressed. Comments included: "When I have concerns, I tell staff and they do everything they can." "If I am not happy about something, I will tell staff." "Because staff are very nice to me, I don't see any need to complain." One visitor told us, "I spoke up before as I found that staff were all going on break together – but now it is improving, they are more hands on."

However, others were less positive. One person said, "When I raise a concern about staff taking too long to answer a buzzer, the manager, she sticks up for staff." A visitor told us, "I don't have any visitor's chair in the bedroom, it is always awkward sitting on the edge of the bed. Recently I came in and the bedroom was smelling awful, it was because some dirty dressings were left in the bedroom, staff told me it was the district nurse that left it, it was a good thing I was in that day, who knows how long it was going to be left in (relative's) bedroom"

We saw a complaints procedure was displayed in the home, although this was not the same as the complaints procedure given to us by the registered manager. We looked at the complaints file. There was no record of the two complaints the visitors told us about above. The file showed one complaint had been received since our last inspection. The issues raised in this complaint had also been referred to safeguarding. We saw correspondence from the registered manager to the complainant which acknowledged receipt of the complaint but did not address any of the issues raised by the complainant. There was no evidence to show the complaint had been investigated in line with the provider's own complaint procedures. This was a breach of the Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our two previous inspections we found governance systems were not effective as issues identified through quality audits had not been addressed. At this inspection we found continued regulatory breaches which demonstrated the service had not improved. We concluded the service was not well-led.

The registered manager had been in post since 1 March 2016. People and visitors we spoke with told us they thought the home was well managed and described the registered manager as approachable and fair. Comments included: "The home is under new management, I know the new manager, she often walks about in the dining hall." "Our new manager is lovely, very approachable." "There is a new manager, she's a nice woman." "I don't know the manager, I am not bothered so long as I am looked after."

We asked staff about leadership in the home. One member of staff said, "The manager and deputy tend to stay in the office. We would like a little more help from them. They don't come and work with the staff."

Our discussions with the management team over the course of the inspection indicated a lack of knowledge and oversight of what was happening in the service. Questions we asked of the registered manager and their responses showed they were not always aware of events and even when they were aware they had not always taken appropriate action to ensure people were safe. For example, our review of accident and incident reports quickly identified issues in relation to bed rails which were confirmed when we checked the bed rails in people's rooms and looked at their care records. Yet these issues had not been identified by the registered manager or provider. We observed both the registered manager and deputy manager stayed predominately in the office and were not visible out on the floor leading, directing and supporting staff.

Quality audit systems were in place but these were not effective as action had not been taken to resolve issues. Some of the information recorded showed checks had not been completed correctly, although this had not been identified by the registered manager or provider. For example, we saw the complaints summary for 2016 showed there had been one complaint, yet our review of the complaints file showed there had been four other complaints in 2016. Weekly checks of bed safety rails identified none of the safety issues we found during the inspection even though the provider had a copy of the bed safety rail guidance published by the Medicines and Healthcare products Regulatory Agency (MHRA) which highlighted the areas of risk we found. Similarly monthly checks of hot water temperatures identified wide variations in temperatures every month dating back to August 2016, yet no action had been taken to address this until we raised the issue on the first day of our inspection.

We saw a monthly summary of accidents and incidents was recorded. However, our review of care records showed not all accident and incidents were captured in these summaries. For example, daily records showed two people had been found with their leg or foot through the bed rails on two different dates in April 2017, another person had left the home and had to be brought back by staff and another person had been found with unexplained bruising, yet none of these incidents were reflected in the summary. Numerical data showed how many incidents/accidents had happened in the morning, evening and night, yet there was no analysis of the information to identify trends or themes or look at 'lessons learnt' to prevent recurrences.

The registered manager told us the provider visited weekly and carried out a monthly audit. We saw the report from their most recent audit on 29 March 2017. This showed checks they had made of different records and listed some planned refurbishment. However, none of the issues we identified at this inspection were noted in this report. There was no evidence to show the provider had been involved in any discussions with people who used the service, relatives or staff to gain their feedback of the service.

Several people we spoke with told us they had to wait a long time for staff to attend to them when they rang the call bell. We asked the registered manager how they monitored the response time to call bells. They told us the call bell system had a facility to monitor response times however this had not been set up so they could not use it. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the rating from the last inspection was displayed in the home and on the provider's website as required.

We saw the registered manager held regular meetings with key groups of staff including care staff, senior care staff and nurses. Minutes from these meetings showed discussions included medication errors, accident reporting, recording on MARs, improving staff knowledge of people and other operational issues. We saw staff had been given a 'You said, we did' document to capture feedback given via a 'suggestions box'. This included improvements made to the nurse handover communication and operational matters such as pay and breaks.

We looked at the results of a survey carried out with people who used the service and their relatives. The information was displayed on noticeboards, meaning people had easy access to it. We saw good feedback had been received about staff and the building, and that people felt well looked after. Suggestions for improvement were more one to one time between staff and people who used the service, meals were felt to be 'repetitive', and improving staff response times.

We saw the registered manager had responded to issues raised. Where staffing numbers were queried the response was, 'The home is fully staffed'. People had said the home needed a deep clean, and the response was, 'The home is cleaned every day and a deep clean is undertaken on a regular basis/when required.' People had asked for more trips out, and the response was, 'We do encourage family and friends to take residents out where possible.' Although the registered manager had responded to the issues there was no evidence to show the issues had been investigated or that any action had been taken to address them.

We looked at minutes of meetings held with people who used the service and their relatives. We saw a range of areas had been discussed at the most recent meeting in December 2016. These included activities, meals, call bells, concerns about lift breakdowns and the CQC inspection report.