HC-One Limited

Priory Gardens

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Priory Gardens took place over two days, 15 and 21 May 2018 and was unannounced on both days. At the previous inspection in March 2017 the service was rated requires improvement with two breaches of regulation for safe care and treatment and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to at least good.

Priory Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Priory Gardens accommodates 72 people in one adapted building divided into three units. One of the units, Grace, specialises in providing care to people living with dementia. Nightingale supports people with predominantly nursing needs and Symphony supports people requiring assistance with daily living. On the days of the inspection there were 46 people living in the home.

There was no registered manager in post at the time of the inspection. The home was being supported by a relief manager, an area director and an area quality director. 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.

People and relatives told us there were insufficient staff to provide safe and effective care. Many relatives advised us they came in to assist staff otherwise their relation would not be cared for properly. Staff were extremely busy, and became task-focused in their roles due to the continuous demands on their time. This was to the detriment of team work on occasion. Staffing rotas did not reflect the amount of staff needed in relation to people's true dependency levels.

Risk management was not consistent and while some had been improved, the correlation between care plan guidance and risk management had not been identified.

Staff were confident in how to report any concerns. We found reporting of such incidents was mostly timely but evidence of lessons learned was limited, partly due to the new management team.

Medication management was not always safe as people had missed medication and records were sometimes incomplete.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. The provider had allowed legal safeguards to lapse with incomplete records of people's mental capacity, and staff's understanding of these safeguards was poor.

Although people had regular food and fluid, their experience was not in line with best practice in every instance and relatives were relied on to assist people.

Staff had received induction, supervision and training although we found some issues with recruitment records and records of agency staff. The manager relied on resources from the provider to keep abreast of current practice.

Most staff treated people with kindness and consideration on an individual basis. However, the pressures of too much to do showed on occasion when people's needs were ignored as staff were dealing with others. Dignity and privacy was promoted in most instances and we saw some discreet interventions when people needed more personal care.

Care documentation, whilst still being amended, was not always consistent or accurate in the new records. There was a lack of cohesion in some records with staff not always being aware of what was contained in them. The delivery of care was task-driven rather than based on person-centred involvement.

Although activities were organised in some areas of the home, there was little evidence of personal interaction with people, especially those in their rooms. Complaints were acknowledge and responded to well under the current management structure.
The home had no registered manager and had had a number of different managers. Although they had all attempted to drive forward change, the lack of consistency and oversight meant people and staff had differing knowledge and understanding of who was in charge and what direction the home was going in. There was no shortage of commitment to transform the home but the differing personnel each had their own vision. The current management structure had not been in the home sufficiently long to ensure sustainability.

The governance framework was being used but further work needed doing to ensure all aspects of care delivery was assessed and evaluated, particularly considering people's direct experiences.

The provider was offering guidance and support, and regular briefings to all managers, and was keen to establish consistency of management in the home to provide stability.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, two of which were continuing from the previous inspection.

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.

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 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.

We found staffing levels were insufficient to support people safely or in a timely manner.

Risk management was not always complete and medication was not always administered correctly.

Staff were knowledgeable about how to report safeguarding concerns and infection control procedures were adhered to.

Is the service effective?

Requires Improvement

The service was not always effective.

People had mixed experiences of mealtimes, and we found team work was better on some units.

The provider had not ensured all requirements of the Mental Capacity Act 2005 and its associated Deprivation of liberty Safeguards had been met.

Staff had received regular supervision and most training was current, although further input was required for agency staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff displayed care and compassion on most occasions but there were intervals when this lapsed as staff had conflicting demands on their time.

Records did not always evidence sufficiently how people, their relatives and other key individuals had been involved in care planning decisions.

Privacy and dignity was promoted in individual interactions but not everyone's needs were consistently acknowledged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People felt there was not much to do despite some activities being organised.

Care records, although still being updated, still had gaps and inconsistencies of information. Not all were being correctly followed.

Complaints were appropriately managed.

Is the service well-led?

Inadequate

The service was not well led.

There had been no registered manager in post since December 2017, and although there was always management cover this had been inconsistent. This meant staff and people felt unsettled and upset at the amount of changes.

Quality assurance systems were comprehensive but omitted some key aspects of care delivery and did not identify our main concern around staffing.

The frequency of agency staff, especially on the nursing unit meant staff were not given appropriate guidance and due to the frequent management changes a clear vision for the home was not yet embedded.

Priory Gardens

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 15 and 21 May 2018 and was unannounced on both days. The inspection team consisted of three adult social care inspectors on 15 May 2018 supported by an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 21 May 2018 two adult social care inspectors returned to complete the inspection.

Before the inspection we requested a Provider Information Return (PIR) which was returned to us. 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 checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with eight people using the service and seven of their relatives. In addition, we spoke with ten staff including four care assistants, one nursing assistant, one nurse, the wellbeing co-ordinator, the area quality director, the relief manager and the area director.

We looked at ten care records including risk assessments in depth and other sundry records, two staff files including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

During the last inspection in March 2017 the service was found to have poor risk management. During this inspection we found some further issues with risk management and also issues with medication and staffing.

We found significant concerns with staffing levels as people had to wait for attention or we found relatives were substituting care provision as they observed how busy staff were. One person told us, "They leave me in bed for my breakfast. So that I can reach it, they put it on my belly. My porridge is cold because they are waiting for another carer to come and lift me up, I need two." Another person told us, "I haven't been asked today if I want to get up. I have not had my hair combed today." One relative said about their relation, "I came this morning at 10.15am and they weren't up, not dressed, no food or drink."

Staff also raised concerns about staffing levels. On Nightingale, staff told us there was usually one nurse and three care staff on duty between 8am and 8pm. They said this was not enough to meet people's needs due to the level of dependency. Staff told us 15 of the 17 people on the unit required two staff to assist them and 10 people required assistance from staff with eating and drinking. They told us they relied on one relative to provide care for their relation during the day. On Symphony, there were five people who required two staff for safe transfers and three who needed full support with nutrition yet their staffing ratio was the same as Nightingale.

One relative on Grace stated they visited most days but at different times. They told us, "There are not enough staff when I visit and this impacts on other aspects of care. I always have to look for staff when I visit. I feel they rely on me to be an extra pair of eyes. There can be occasions when no staff are in sight. Staff rotation is not good for people living with dementia." One care assistant said, "I enjoy working here but I don't like moving around the different units as this makes it hard to remember what people need." Another care assistant confirmed this practice was the norm meaning it was difficult to get to know people.

We observed staff were constantly busy. We saw a large number of people stayed in their rooms and this meant people in the lounge were often unattended. We observed many periods where staff were not visible. One care assistant said, "Staffing levels are a struggle as I can't be in two places at once. If a person needs support, others are left to wait." During lunchtime on Grace one person asked to use the toilet and was told by a care assistant, "We can't while we're doing lunches. It's protected mealtimes. Cross contamination." When questioned by the inspector they continued, "We can't because [name] needs two and a hoist. There's only two of us and we're serving meals." When asked if there was any other help such as a manager, they told us, "No, there is no one to call on."

The provider used a dependency tool which was based on people's individual needs, however we found these did not match our observations or the view of staff. In addition, the dependency tool for March 2018 recorded 10 people as very high dependency on Nightingale but the staffing allocation was the same as on Symphony which had no one at this level, i.e. four staff on each during the day and two at night. On Grace, 11 people were assessed as having medium or high needs, and yet only two staff were allocated during the

day, and one during the night despite people being unsettled. This meant the information regarding people's dependency needs did not correlate to the staffing levels suggested.

Staffing rotas revealed the home relied on agency nursing staff to cover most weekend and night shifts. In addition, there were fewer staff on duty at weekends. During one weekend there were only nine staff for the whole home during the Saturday, six of whom were care assistants and on the Sunday there were only five care assistants. During the night shifts, the numbers of care assistants dropped to three. One care assistant advised they worked five 12 hour shifts consecutively as a usual pattern. These provide evidence of a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staffing levels

Despite the heavy reliance on nursing agency staff, we found on the first day of the inspection appropriate checks had not been updated to ensure nurses still had the right to practice. This had been remedied by the second day of the inspection. We checked recruitment procedures and found these were not robust as there were gaps in people's interview notes and also checks had not been made where people had gaps in their employment history. This is evidence of a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as recruitment checks were not robust.

We saw personal emergency evacuation plans (PEEPs) were in people's care files. These were up to date and provided detailed information. However, some were very lengthy and provided too many options for staff to read quickly in the event of an emergency.

We found risks to people were not always well managed. Risk assessments were in place for areas such as nutrition, skin integrity, falls, choking and mobility and we observed safe moving and handling practice. However, we found the risk management strategies were not always being followed. For example, one person's risk assessment showed they were at very high risk of developing pressure sores. A chart in their room showed they should be repositioned every two hours during the day. Yet we saw from the chart there were gaps of up to five hours where the person had not been repositioned. We saw another risk assessment for this person which stated when they were in their bedroom checks should be carried out by staff hourly and recorded as the person could not use their call bell. There were no records to show this was happening and staff were unclear if these checks had taken place.

One person used a pressure relieving mattress but staff were unable to confirm the mattress setting as it was difficult to read. A further person was supposed to have a pressure relief cushion in their wheelchair but we observed they were not sitting on this during breakfast on the first day. We found the suction machine which is used to assist people in the event of aspiration at the back of a cupboard without adequate checks to ensure it was working properly. We also found one person identified as at risk of aspiration had not had their needs sufficiently reviewed to minimise risk.

One person's dependency score was rated medium rather than high despite needing frequent observational checks by staff. This was because their behaviour was rated as 'mild confusion'. There was no risk assessment in place regarding the initial reason for the monitoring despite them also having an irregular sleeping pattern which meant staff needed to keep checking their whereabouts through the night. These are a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks were not sufficiently assessed or mitigated, and there was insufficient evidence care and treatment was being delivered safely.

Accidents and incidents were logged by staff and we saw responses to the immediate incidents were appropriate. We found most were reviewed by managers to see if risks could be further minimised. If

equipment was a possible risk minimiser, the reasons why this was not always appropriate were also recorded such as in the use of bed rails.

We found medicine management was not safe. We found people had not always received their medicines as prescribed. One person told us, "My tablets are usually late." We saw one person was prescribed three steroid tablets to be given in one dose daily. The medication administration record (MAR) showed the person had only been given one tablet over a four day period. This meant the person had not received the correct dose of their medicine for four days. We found two examples where people had not received their pain patch as prescribed.

We saw entries in another person's daily record which showed staff were applying cream to sore areas, however, no cream had been prescribed on the person's MAR. We found other records of cream application to be accurate and completed well. Eye drops were in use with no date of opening so staff had no knowledge if they were still safe to use. We saw protocols were in place for 'as required' medicines. However, we found staff were not always recording on the MAR the time when pain relief had been given. This is important to make sure there is a sufficient gap between doses.

We saw a daily medicine audit system was in place which the nurse told us they completed. The audit checked all aspects of the medicine process such as whether medicine records had been completed correctly and the management of controlled drugs. However, we saw the audit had not been completed since 12 May 2018 and therefore the issues we found had not been identified. These are a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not managed safely or properly.

Medicines were stored safely and securely and their administration was done patiently with people. Room and fridge temperatures were checked to ensure safe storage temperatures were maintained. Systems were in place for ordering and returning medicines. Where medication was administered covertly, appropriate permissions had been obtained including the pharmacist. The relief manager advised us staff's medication competency was assessed annually and, as part of the monthly medication audit, staff were observed administering medication.

One person told us, "It's OK. I'm safer here than at home on my own." Staff we spoke with understood how to recognise potential signs of abuse, report safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the manager who they were confident would deal with any issues promptly and appropriately. Staff were also aware they could report concerns to other relevant agencies. We found safeguarding concerns were addressed appropriately.

We found the home was clean and there were no malodours. Relatives told us the home was always kept clean. Systems were in place to ensure infection control practices were followed. We observed staff wore personal protective equipment such as gloves and aprons appropriately. Facilities were available to ensure good hand hygiene, including hand sanitiser.

All premises and equipment checks in relation to moving and handling equipment were carried out and planned in accordance with requirements.

Requires Improvement

Is the service effective?

Our findings

Not everyone spoke well of the food provided. One person told us, "I'm not keen on the food, we get some funny mixtures. It's often cold and not very nice to taste." Another person said, "I have soft food it's not very special; it's not tasty, it's very bland." They did tell us, "I ask if I want a drink but they are very busy." Another person confirmed they drank sufficiently, "I get lots to drink when they come round." However, a further person told us, "The food is good, we get a choice and they'll make me something else if I don't like it." We saw drinks were available to people in their bedrooms and the communal areas.

During breakfast on the first day we observed two people were brought scrambled egg sandwiches which neither touched. Staff removed them without encouraging either person to eat them.

We observed lunch in all three areas of the home and found a mixed experience for people. In Nightingale and Symphony people had nicely laid tables and were offered a choice of beverage and meal. Interaction between people and staff was prominent. We saw a staff member sat at a table with one group of people chatting and providing assistance where needed. A relative was sat at another table having lunch with their family member. There was a calm pleasant atmosphere with music playing in the background. Food was served from a heated trolley and we saw staff showed people the meals so they could choose what they wanted.

In Grace people were not supported to eat. We observed one person positioned too far away from the table and no adjustments were made by staff, another person put their napkin in their soup and then pushed their bowl away. Of five people in the room, only four had soup and one person had nothing. No staff were present in the dining room for five minutes as they were serving meals elsewhere in the unit. One person was eventually supported by kitchen staff on an individual basis as specified in their care plan. People were given a visual choice.

We also observed another person with a bowl of soup by their leg in their bed which they were unable to reach as they were laid back. They asked the inspector to assist them to a better position. When questioning a care assistant as to why this person was in bed, they replied, "They are aggressive and will change their mind if we try and help them." When the position of the soup was highlighted and the care assistant asked if the person was supported, they replied, "They don't want to be supported." Another staff member stated "We like to give them independence." However, our observations did not indicate their independence was being promoted. We later observed this person eating independently while out of bed.

For people at nutritional risk food and fluid charts were completed with targets and totals. However, it was not clear what or when action was taken if the person had not met their target. Staff knew how to access specific information about people's nutritional needs in people's care records. Weights were reviewed regularly and monitored.

Staff told us most of their training was accessed through e-learning followed by completion of assessment booklets and was kept up to date. Staff confirmed they received supervision and we saw records which

mirrored this. New staff had a twelve week induction which included shadowing more experienced colleagues on shift and the completion of the relevant competences. They were also assigned a mentor to oversee their progression.

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. Capacity assessments had been completed for some aspects of care with evidence of appropriate questioning. However, there was insufficient evidence to show the correct people had been included in the decision-making as records did not include sufficient detail.

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 authorisation 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.

The nurse told us none of the people on the nursing unit had a DoLS authorisation in place which meant people were deprived of their liberty without appropriate authorisation. However, one person's care records stated they had a DoLS in place from 23 June 2017. This was incorrect and we saw an application had been made for an authorisation on 16 May 2018. We spoke with the visiting turnaround manager who advised many authorisations had lapsed and so they had just completed a piece of work identifying who had current authorisations in place (three people) and was awaiting the outcome of a further 21 applications.

Staff were unaware who had a DoLS in place but one told us everyone should have who lived in Grace. Another care assistant said, "I'm not sure who would need one or who has one. But to be honest, all the people in the home would not be allowed to leave as it's a nursing home." This shows staff did not understand the significance of a DoLS. We also saw in one person's care record reference to a DoLS application but the person was deemed to have capacity so this meant the application would have been void.

One person was on 15 minute observations due to a safeguarding concern but entries were completed for fixed times and did not evidence the check had taken place as information was minimal. This had been implemented since April 2018 and yet no DoLS application had been made until 9 May 2018. There was no evidence this monitoring had been reviewed to see if it was still proportionate and least restrictive.

We saw restrictions were in place for some people. For example, one person's care plan showed a sensor mat was in place to alert staff when the person moved around and another person had bed rails in place. There were no mental capacity assessments or best interest decisions recorded for either of these restrictions even though both people had a diagnosis of dementia. On the second day we found these had been completed retrospectively.

We saw a mental capacity assessment for one person completed retrospectively on 15 May 2018 in relation to their nutritional needs as they had refused to accept advice from the speech and language therapy team to have a soft diet due to risk of choking. The assessment had been completed on 20 February 2018 and stated there was to be a best interest meeting on 28 February 2018. There was no evidence to show this had taken place. These are a breach of Regulation 11Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the need for consent was not obtained in line with the requirements of the Mental

Capacity Act 2005.

Care records we reviewed showed evidence of access to healthcare professionals. For example, the GP, district nurses, community matrons, SALT and the optician. There was a representative of the SALT team in the home during the inspection and they spoke positively of how well staff responded to their advice and they told us they felt staff knew people well. However, this did not match our findings. The relief manager had built positive relationships with local services and gave examples of where different options had been considered for people due to discussing their needs in more depth.

Staff spoke of positive team work in the home. We found daily handover and communication records completed by staff were detailed and relevant assisting staff to pick up key issues.

The relief manager advised they kept their knowledge current by referring to the provider material available which was extensive, and would also reference other managers as necessary.

The environment was bright and welcoming, and people had access to communal areas as well as their rooms during the day. Signs helped people to orientate themselves and access to the garden was through patio doors which were utilised well.

Requires Improvement

Is the service caring?

Our findings

People spoke well of most staff. One person said, "They are very kind usually." Another person told us, "They are kind to me. I wash and dress myself; they help if I need it." A further person said, "I love it here. The girls are lovely, treat me with respect and are kind and caring. They make me a cup of tea if I wake up during the night. I can have a bath when I want, I'm having one this morning." One relative said, "They are very respectful of them, at least when I am here." Relatives we spoke with described the staff as kind, caring and very good and said they could visit at any time.

We saw staff were cheerful and friendly with people, having a chat with them whenever possible. Staff called people by name and were caring in their interactions. Most people looked well groomed. During the morning drinks round on the first day we saw people were offered visual choices to aid decision-making. Staff were pleasant and friendly in their manner. At lunchtime on Symphony on the second day we observed one person start singing and staff joined in, promoting a happy atmosphere.

We observed one person knock a coffee table over accidentally and staff were quick to respond with reassurance and positive interaction. Another person became very agitated and unsettled and staff were quick to respond and reassure. They were supported to sit near an open door onto the garden but stated they were too cold, so the care assistant supported them to their preferred location. A further person was asked if they preferred to sit in a more comfortable chair.

We saw staff treated people with respect, knocking on doors and announcing who they were before entering. We heard one care assistant ask, "Am I OK to come and take your breakfast in?" One person referred to their physical discomfort and staff discreetly supported them to their room to apply some cream.

We saw one person in distress and they were offered a cup of tea which was duly brought. The person cheered up. This prompted another person to request a cup of coffee and they were reassured by 'kettle's on', and this was also given. However, another person was frequently asking to get out of their chair but staff did not provide any reassurance and the person eventually fell asleep.

One person had a lot of food on their top and around their mouth and staff told us, "We will get round to it." On Symphony one care assistant was completing records when a person requested assistance to go to the toilet at 11.50am on the first day of the inspection. The care assistant replied, "I will, after this one" and continued to complete their record sheets. Another member of staff came in and requested assistance so this care assistant then left the lounge. After a period of five minutes the senior staff member came in and pressed the alarm as the person still needed the toilet. It was a further ten minutes before staff returned to assist which they then did.

On the second day of inspection we observed a person enter a toilet independently but once in there become very distressed shouting very for help. A care assistant was supporting a person with their breakfast next door and despite an inspector and CCG nurse sitting outside in the hall area did not come to attend to the person. The CCG nurse responded as no staff appeared.

One person during breakfast, although asked if they would like anything else, was not given an appropriate response as the care assistant said, "Whatever" in response to their question as to what was available, providing insufficient guidance or support for the person to make an informed choice.

One relative expressed their concern at the neglected appearance of their relation who used to pride themselves on looking smart.

We asked the relief manager how they ensured the service met people's needs as defined under the Equality Act 2010. They explained all stages of the recruitment procedure for staff adhered to the principles of the Act, and the processes from pre-admission assessments right through to living in the home meant people's needs were identified, reviewed and met as far as possible, such as meeting specific religious needs.

Requires Improvement

Is the service responsive?

Our findings

People felt there was not much to do in the home. One person said, "We have a sing-a-long maybe every few months, that's OK. I watch the TV as there's not much else to do." Another person told us, "The nurses put the TV on when they come; they don't ask me what I want to watch. I don't go out at all. I stay in bed all the time."

A further person did state, "We play bingo sometimes and they take me down then; I love that." This was observed on the first day of the inspection where people engaged well with each other and became animated. People who struggled were given discreet assistance and responded well to staff who showed interest and consideration to people. During the morning on the first day a 'Pets as Therapy' (PAT) dog came into the home but due to the number of people to be seen did not spend more than a few minutes in each place.

The home had a well-being co-ordinator who said "We have activities like crafts every week and staff come from all the three areas in the home to help." One person told us, "Church fetched me a palm cross at Easter. I'd like to have a church service in here." We observed the wellbeing co-ordinator enter Grace unit attired in an apron and feather duster asking people if they liked to wear aprons like that. They also asked if people liked the smell of bleach. People did not respond. One person continually asked if they could return home during this, but staff did not respond to their concerns. In Symphony the TV was turned off without consultation even though some people were watching it and only then were they asked which DVD they would like on. In Nightingale on the second day a DVD was put on for people and they were only asked if they liked it after this had happened.

During our time on the nursing unit we saw no activities taking place, although the well-being co-ordinator frequently visited the unit. We saw people being asked if they would like to go downstairs to play bingo in the afternoon and some people went. One relative told us, "Activities up here are sparse. The activity lady came up this morning but has done nothing. Yesterday she came up with a student and brought them into the lounge but didn't see her after that. There's nothing going on."

One of the senior managers told us the home was in the process of updating people's care records. They told us the orange care files were the ones which had been updated and the blue ones were still to be done. However, we found gaps in all the files we reviewed.

We saw one person had dressings on their left arm and right ankle. We looked at their care records. In the daily records for May 2018 we saw the person also had wounds to their legs and a dressing had been applied. We saw a skin integrity care plan dated 27 April 2018. This showed the person had a skin tear to their wrist which had steri-strips applied. There was no mention of the leg wounds. We asked the nurse if there were any wound care plans or treatment plans for these wounds. The nurse checked and said there were not any and that they would do them later that day. We asked when the wounds had last been dressed and the nurse said they didn't know and they would do them later that day. They said they did not know there were steri-strips on the arm wound.

We saw the person's feet and lower legs were red and swollen. The daily records showed the GP had visited the day before the inspection and prescribed antibiotics and recommended the person's feet were kept elevated but we observed the person was sat with their legs down. We asked the nurse who said they had tried to elevate the person's legs on a stool but staff said the person kept trying to sit on the stool. We asked if they had considered other options such as a recliner chair but the nurse said they didn't think they had a spare one.

A body map in another person's care records noted on 9 May 2018 they had a broken area to the side of their right knee. The daily records for this person noted in the days leading up to the inspection the person's sacrum was red and sore. One of the care staff confirmed this person's sacrum was red but said the skin was intact and staff were applying Conotrane cream. They told us the person had a dressing put on their knee on 11 May 2018. There was no information in the care plan about the treatment or management of either of these. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not know about people's health care needs and these were not being met.

We saw another person had been admitted to the home seven days before our inspection. We looked at this person's care records and found a pre-admission assessment form had been completed which showed the person was at risk of falling and required assistance from staff with all aspects of personal care. Daily records also noted the person's sacrum was 'red and sore'. There were no care plans or risk assessments in place for this person, apart from a care plan about activities. We checked with the nurse who confirmed care plans and risk assessments had not been completed for this person. This was not in line with the provider's own policy of completing an initial 7 day care plan which evolved as the service got to know the person better.

On the second day of the inspection we found a 7 day care plan had been completed after we had highlighted this. A PEEP had only been completed on 19 May 2018 (eleven days after their initial admission).This was reflected by completion of some other relevant care documentation including mental capacity, skin integrity, falls, continence care, nutrition and dependency but not all. This person was deemed at medium risk and yet we observed them with high levels of anxiety, requiring frequent reassurance and unstable walking ability as they set off alone as no staff were present. This person only calmed once their relative visited. One of the care records actually referred to their relative providing support for mealtimes on a daily basis. If they had not been available the care plan did not refer to the need for staff support.

In other care records we looked at we found mention of one person becoming distressed during care support but no guidance for staff as to how best manage this. Likewise, in the use of equipment for moving and handling there was no methodology recorded. Other care plans were not being followed. In one person's care plan it stated they wore glasses yet we did not observe the person wearing these, also they did not like being on their own and yet remained in their room the whole time of the inspection which was confirmed by a care assistant. A further care plan stated one person required help with personal care but would often refuse. Although it directed staff as to how to encourage the person to accept it, we found evidence of 25 days out a possible 30 where care had been refused. Staff were directed to contact the local mental health team but we could find no evidence this had happened. Neither were there any records to indicate what had led to the refusal each time which would have enabled staff to perhaps reconsider their approach.

We observed a care assistant completing positional charts en masse in Symphony during the morning of the first day which meant the record was not contemporaneous, and another person's records had no indicators by 11.55am on 21 May 2018 that they had had any assistance with personal care and yet they were up and dressed. Their records stated they had not had a shower for the whole of April 2018 as none

were recorded. These are examples of a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care records were incomplete and not completed in a timely manner.

The provider had a 'resident of the day' evaluation tool which ensured all key aspects of that person were discussed at least monthly with key people such as the housekeeper, nurse, senior care assistant and cook. This was to ensure all needs were being met as far as possible and any issues followed up on promptly. We found approximately two-thirds of these had been completed in April. This tool was also used in conjunction with a care plan audit and we could see progress was ongoing in regards to this. However, it was not as clear if these actions had been completed.

People and relatives told us they knew who to go to if they had any concerns. The complaints procedure was also accessible on the relatives' noticeboard. One relative told us they had raised some concerns with the relief manager who had sorted them out and had checked with their family member and them that they were happy with the action he had taken.

Two other relatives spoke of concerns they had raised regarding staff, both in relation to conduct and practice. One relative was not happy as the staff member was still working and they felt the issue had not been addressed although the relief manager advised us this investigation was ongoing and the staff member had been removed from working with this person, and the other had discussed concerns with their relative's specific equipment not being used properly. This had led them to complain on multiple occasions with eventual success. Complaints records showed appropriate responses had been made to those which were recorded as such. We found not everything was recorded as a complaint which possibly should have been. The service had received compliments for staff responses, in particular for end of life care.

Inadequate

Is the service well-led?

Our findings

One person told us, "I'm happy at moment but hoping to get somewhere permanent." One care assistant told us, "I like working here."

People did not feel their opinion was always sought. One person said, "I've never been asked my opinion. If I had a problem, I would tell the staff." Another person also told us they had not been asked their views on care in the home. Two people said they had no idea who was in charge and one specifically told us, "They are always short of staff; I don't know who is in charge of that."

Relatives were equally vague about who was in charge. One told us, "I'm not sure who the manager is." Another said if they had any problems, they would, "Tell whoever is in charge. No, I don't know who that is, so would tell the carers."

We observed a lack of leadership evident on specific units especially nursing on the second day as this was an agency nurse who was rightly focusing on their particular tasks such as administering medication. However, they had no idea a multi-disciplinary meeting was to be held and no preparation had occurred. This lack of communication was heightened when further staff entered the unit to assist but had to liaise with a care assistant for information. At 11.15am the care assistant admitted a colleague was now in the meeting, and their other colleague was still getting people up. They had only just finished supporting someone with their breakfast. The nurse was still administering morning medication at 11.25am.

The service did not have a registered manager. One relative said, "There are too many managers and no responds to concerns." Another relative said, "Management turnover is too high and I'm not happy with any so far. They never stay, and there is no ownership or systems in place to see how the home is run." Staff also raised concerns about the management turnover. One care assistant said, "There's too many and we don't know what's what sometimes." Another said, "Lots of managers is disruptive."

The relief manager had been in the home for five weeks at the time of the inspection, having taken over from a turnaround manager. They were due to work alongside a new manager but they gave notice just prior to the inspection so the provider was in the process of seeking a further manager. The relief manager assured us they would be remaining in the home pending the arrival of a permanent manager to promote consistency.

We asked the relief manager what they felt they had achieved in their short time in the home and they advised they felt staff morale had improved as had the environment but they were aware of ongoing issues with the care records. They advised they had reviewed staffing levels and felt they were appropriate at the current time, if anything they were over-staffed. This did not match our findings. They told us they had the authority to increase staffing ratios if needed. They were making a deliberate effort to reduce the use of agency staff which was reflected in the care assistant roles but they still struggled to recruit nursing staff.

We asked what they felt the key risks to the service were and they told us ensuring staffing levels did not

deteriorate and to ensure they kept new recruits on board. They were very keen to minimise the use of agency nurses as they appreciated the impact of different staff.

The relief manager was supported by a new in post area director and area quality director who had been in the home since January 2018. They provided direct support and were present during the inspection. The relief manager advised if they had any queries there was plenty of support available.

There was a quality assurance system in place. However, we found the governance systems omitted to assess the impact on people due to insufficient staffing. Additionally, the audits had not identified the deficiency in the records and care in relation to skin integrity and wound management which we found resulting in unsafe care and treatment for some people. Further risks we found around medicines management, pressure care, incomplete recruitment records all provide evidence of the deficiency of the governance systems in place. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as governance systems did not monitor sufficiently the safety of the services provided nor were risks appropriately mitigated for people.

The manager and area quality director completed audits for medication, clinical indicators such as weight, pressure ulcer, falls, bed rails and infection. These were all clear and detailed, with evidence of reasons why events had occurred such as illness, and actions taken. These audits fed into monthly reports sent to the provider. In addition there were audits for 'dignity in dining' and health and safety. Monthly reports were completed for each person on the key clinical indicators and showed what action had been taken.

We asked the relief manager how they ensured good practice and they advised us through twice daily walk arounds including weekends, and working on the units, through training and supervision, and regular discussion with staff. They also conducted spot night visit checks to ensure all staff were seen in practice. The latest night visit had queried staffing levels but it was noted this had been reviewed. We could not see what this review stated. They also had visits from the Clinical Commissioning Group quality leads and the local authority who provided further external scrutiny and identified areas for improvement.

The walk arounds considered how people looked, whether documentation had been completed as required by picking random samples, observing interactions between staff and people and ensuring people had their call bell in reach if in their room. There was also more general environmental observations and feedback obtained from specific people. Any issues identified on the first walk around needed to be resolved by the second and we saw evidence of this. However, the lack of support for people had not been identified as the questions did not consider this aspect and the walk arounds were formulaic.

In addition to the general walk around, there was a clinical walk around which focused on who was unwell, anyone recovering from a fall or having returned from hospital or whether anyone needed further external medical input among other areas. If documentation had not been completed as required, the relief manager scheduled a supervision for the staff member concerned.

We saw the provider had last sent a feedback survey in June 2017. The responses were mostly positive including comments on areas such as kindness, care, safety, food and staff but a few issues had been raised about the home management at that time. The responses had been analysed and responded to by the provider in a 'Have your say' report dated April 2018.

There was evidence of regular resident and relative meetings which were scheduled and advertised on the noticeboard. Topics discussed included meals, laundry, activities and some staffing issues which we later found were addressed. There was also a copy of a Residents' newsletter which had photographs of the

recent care home open day celebrations. A manager surgery was advertised on every last Tuesday of the month although no one had attended the last session.

Staff meetings were held on a monthly basis which gave clear advice and set high levels of expectation. They also praised staff for areas where they had done well. There were also heads of department daily meetings including at weekends which included care, housekeeping and catering to ensure there were no significant issues and if there were, these could be addressed promptly.

The provider had a detailed action plan which they continued to send us post inspection to provide reassurance of their intent to improve.

The ratings from the previous inspection for the home were displayed as required under statutory legislation in the home and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely and risks to people were not appropriately mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment and employment checks were found to be incomplete and out of date.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not understand the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards. Capacity assessments were inconsistent and people's deprivation of liberty was not always authorised.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were unable to identify some of the issues we found with poor or non-existent records, and even where records existed staff did not follow them. Quality assurance measures had failed to identify the issues we found with staffing levels.

The enforcement action we took:

Warning notice

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 Staffing levels were insufficient in meeting people's needs safely and in a timely manner.

The enforcement action we took:

Warning notice