Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Lucerne House

Chudleigh Road, Alphington, Exeter, EX2 8TU

Tel: 01392422905

Date of Inspections: 28 August 2013
23 August 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Safety, availability and suitability of equipment	✗ Action needed
Staffing	✗ Action needed
Supporting workers	✓ Met this standard
Complaints	✗ Action needed

Details about this location

Registered Provider	Barchester Healthcare Homes Limited
Overview of the service	Lucerne House is registered to provide accommodation for 75 people who require nursing and personal care. The home is situated in Exeter, Devon.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 August 2013 and 28 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

At the time of our inspection there were 73 people living at Lucerne House nursing home. The service consisted of three units known as Shillingford unit, which provides care for people with dementia; Ide Unit, which provides nursing care for older people, and Alphinbrook Unit, which provides nursing care for people with physical disabilities.

We spoke with 16 people who used the service, along with 13 visitors/relatives to gain their views of the service provided. We also received information from two relatives following the inspection who raised concerns about the standard of care provided and staffing levels. We spoke with 23 members of staff including the senior management team, nursing staff, care staff, ancillary staff and agency staff.

People we met during our inspection told us that they were generally satisfied with the service they were provided with. They often spoke highly of the dedication of the staff team. Comments included, "The staff are nice to me", "All of the staff treat us with respect and consideration", "Staff are lovely. They couldn't do more for me". When asked if there were any improvements which could be made, six people told us they would like to see more staff available. Comments included, "The biggest problem is the lack of staff. This means I have to wait for attention"; "There are not always enough staff. Sometimes I can't find staff to help me"; "I can wait for 30 minutes or more for help. The staff are always busy" and "I wish there were more staff. That's my only negative comment".

Not all the people we met were able to verbally tell us about the care they received and their experience of living in the home. Therefore we observed how staff interacted and supported people, to enable us to make a judgement on how their needs were being met.

Some relatives told us they were happy with the overall care provided. One relative told

us, "The staff understand X, his character and humour". Another relative told us, "We are happy with the care although they do appear to be short staffed at times". Other comments included; "Mum is looked after well. She gets on with the staff. They make her laugh"; "We are appreciative of care. There are incredible individuals within the staff team who go that extra mile"; "There are lots of lovely staff, however, I am not sure there are enough of them. Some people here are very ill and need a lot of attention".

We spoke with a range of health and social care professionals including two GPs; a speech and language therapist (SALT); a care manager; continuing care nurse and a tissue viability nurse. Professionals were positive about the care provided on Shillingford and Alphinbrook saying that staff acted on and responded to their recommendations. However, concerns were raised with us about the staffing levels on Ide Unit and how this impacted on the level of care provided to some people.

During this inspection we identified five areas which required improvement. People did not always experience care, treatment and support that met their needs and protected their rights. This service provided care and support to a high number of people with complex needs and high dependency, including people with palliative care needs. We found that this was not reflected in the numbers of staff available to provide care. People were not always protected from unsafe or unsuitable equipment. There was a complaints system available, however information provided to people about the system was not accurate. Comments and complaints people made were not always responded to appropriately.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

On the whole, where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. People we observed appeared happy when being supported by staff; those people we spoke with told us that staff always asked them if they required help or support before they were assisted. One person told us "The staff are very good, they ask what help I need, and what care I'm able to do for myself". Other comments included, "I tell them what I want and they do that" and "The staff are always kind and courteous. They involve me in day to day decisions about what I do and when I do it".

We saw and heard positive comments from families and visitors about the home during our inspection. One person said "I'm very happy with the care provided in the home; the staff are caring and constantly check it's ok to support Mum." Another told us, "They listen to Mum and do as she wants. They give her choice".

We heard staff asking for people's consent before they helped and supported them throughout our inspection. We saw staff knocking on people's doors before entering rooms and asking how they could help the person. We heard staff acknowledging people when entering lounges and dining areas and addressing them by their preferred name. This meant people were asked for consent and treated in a dignified way by the staff who supported them.

We heard staff explaining what they were doing and offering reassurance throughout their support. For example where a person needed to be moved using a stand aid. We heard how staff explained why they were using the equipment; how the equipment was to be used and checked that the person was happy for this to happen. They reassured the person throughout the process and checked they were comfortable afterwards. This showed staff routinely sought people's consent and involved them throughout the process.

We spoke with a visitor about how consent was gained from their relative about moving to the home, and they told us about a pre-admission assessment. During this visit, they told us, their family member was asked about whether they would like to move into the home and this was checked on several occasions. When looking at people's care files we saw a pre-admission assessment for each person. The information gained was used to inform an initial care plan which was routinely reviewed. We saw from the records that the person and their family were involved in these meetings. These approaches showed how people were routinely consulted about significant events affecting their care and welfare.

Where some people did not have the capacity to consent, the provider acted in accordance with legal requirements. In some people's files we looked at we saw that family members had an enduring power of attorney which meant they could make decisions on the person's behalf. We saw copies of letters from the manager showing how these family members had been contacted to be involved in decision making. We saw examples of where decisions were made on behalf of two people; these decisions were made in meetings involving the local authorities Best Interest assessor as well as other professionals such as GP's. However where other people lacked capacity for every day decision making such as personal security or falls prevention; we were unable to locate best interest assessments which explained the reasons behind how these people's needs were supported. The provider may wish to note best interest decisions were not always recorded for people who lacked capacity.

We spoke with staff about their understanding of consent, mental capacity and best interests. Staff told us they had not received training related to these issues but that they used 'common sense'. Members of the senior management team told us that training about consent, mental capacity and best interests was covered during the safeguarding of vulnerable adults training. However, the provider may wish to note that staff did not recognise this. Staff spoken with did not have an awareness of the Mental Capacity Act or best interest issues or the relevance of these to their role. This could result in people not being supported appropriately with decision making.

We were told that a deprivation of liberty safeguards authorisation was in place for three people. The Deprivation of Liberty Safeguards were only used when it was considered to be in the person's best interest. Where this was the case we saw that best interest meetings took place involving the local authorities Best Interest assessor as well as other professionals such as GP's and specialist nurses. The rationale for the decisions was clearly recorded and when the decision needed to be reviewed we saw current guidance was followed and new orders were gained.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with people living in the home about their needs and how they were helped and supported. Most people gave us a positive view of the care provided by staff. One person who needed support with some aspects of washing and dressing told us, "I'm very well looked after; the staff know what help I need". A family member we spoke with told us, "The staff are very caring and work tirelessly"; whilst another family told us, "The staff are caring, but sometimes there don't seem to be enough of them". We saw staff constantly supporting people and heard staff addressing people respectfully and in their preferred manner. We saw how people's privacy and dignity was respected when being supported by staff.

We spoke with several visiting professionals. One GP told us that staff reported changes to people's conditions in a timely way and that staff were concerned not to miss something important. They told us that staff managed complex tasks safely and competently, for example when using suction equipment or moving and handling equipment. Another GP praised several staff saying they were "very caring, devoted and compassionate" and that overall there was a caring ethos within the staff team. However they raised concerns about the care of people on Ide unit, including those receiving palliative care which they felt related to staffing levels.

A tissue viability nurse told us the service always followed their recommendations, which meant that wounds healed and improved which was evidence that staff followed advice. Another nurse specialist described the improvement to one person, saying that hospital admissions had reduced since their admission to Alphinbrook. We were told that staff were "proactive" and handled health issues well. A care manager was confident in the care and support being provided to people on Alphinbrook but described some concerns relating to Ide Unit. They felt that the Ide Unit was routine and task orientated, for example the use of "toileting rounds" rather than meeting people's individual continence needs. They felt that the unit "gets less staffing input" than other units, which impacted on the delivery of person centred care.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. In the files we looked at all had an assessment of needs which was completed before the person moved to the home. The assessment outlined the needs of the person and how their needs could be supported. People living in the home had their needs reviewed regularly and care plans updated accordingly. We saw how people's daily support needs were being added to as the staff found out more about their needs and preferences. This information and significant daily occurrences such as GP visits were communicated to staff at shift handover meetings.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that the care files had information about diagnosed medical conditions and how to manage these conditions. Conditions such as diabetes or the need for specific diets were clearly recorded. Staff supporting people at meal times told us they were aware of people who required specific diets or food preparation and who required assistance. We saw people receiving the relevant diet and support needed to ensure they received a suitable diet. However where people were taking medication which indicated they should avoid certain foods, this information was not available to kitchen staff and care workers were not aware of all people this affected. This could pose a risk to people.

Where there were concerns about an aspect of a person's care, a risk assessment was recorded in the person's file. The risk assessments highlighted the type and level of risk and included an action plan of what staff should do to support the person. We saw that where a person needed to use a hoist, the type of sling was recorded in the care plan and moving and handling plan. This meant staff were informed about what sling to use to ensure a person's needs were met and their care and safety was managed appropriately.

Some people were at risk of choking. We found risk assessment had been completed and included advice and recommendations from a speech and language therapists. We saw at meal times people were assisted using the equipment specified within the risk assessment and care plan, which reduced the risk of choking. A speech and language therapist told us, "…they have followed swallowing guidelines to the letter…"

Where a person's care plan stated that they had continued weight loss and their nutritional assessment showed them to be at high risk of malnutrition; we saw referrals to the person's GP and speech and language therapist (SaLT) had been made. We saw assessments made by the SaLT and detailed dietary plans to enable the person to maintain weight. However we saw evidence of continued weight loss for one person and review comments which stated to continue with the care plan. We raised this matter with the acting manager who told us they would investigate. We noted that the person continued to lose weight.

We were concerned about the timing of meals on Ide as we found that people could be without food from 8pm until 10.30am the following day, which was a 14 hour gap. The unit manager confirmed that this could be the case. We were also concerned that people having a late breakfast would not be able enjoy a lunchtime meal where there was a gap of only 2 hours. The unit manager explained that there 16 people who needed assistance on the unit and that this impacted on staff's ability to assist everyone at the optimum time.

We were concerned about the timing of one person's medication on Ide unit. Their particular condition required that their medication be given three times a day with adequate space between doses to have the desired effect. We found that the early morning

medication was not given until 10.40am; lunchtime medication was given 2pm and the evening dose was due at 5pm. We discussed the preferred medication routine with a GP. They confirmed that to ensure the medication was effective the person should have a first does early in the morning to assist with their mobility and then at regularly spaced intervals throughout the day. A family member raised concerns about the impact on this person when they did not receive their medication appropriately as they had done when at home. We discussed this with the senior management team.

Where people were being cared for in their room because they were unwell or where they required one to one support, we saw risk assessments were completed. These showed the actions required to help minimise the risk of skin wounds, falls or harm to themselves. For people requiring one to one support we saw staff supported people in the manner indicated. However for other people we did not see staff supporting people in the way the care plans indicated. For example where a person's care plan stated they should have their position changed every two hours we did not observe staff supporting that person and saw the person in the same position for over three hours. For another person where their care plan indicated they were at high risk of developing skin wounds we saw they were in the same position for over two and a half hours. This meant that whilst there were no current skin wound problems the people were not being supported in the way their care plans stated.

Where people's care plans stated that they were unable to use the call system because of their physical disability or cognition; the care plan stated regular checks were required to ensure they were comfortable. We were unable to find any evidence that these checks took place either in the care files or the separate observation records. This meant there was a risk of people not receiving the care and support they may need. Two relatives whose family members could not summon assistance themselves expressed concerns that they could not be confident that staff had the time to regularly check on people.

People's care files were located in locked cupboards or in the nurses stations in areas where people lived and were available to staff. In addition to these files there were separate records for recording daily notes about people's care and support such as food and fluid intake and routine checks to ensure people could go to the toilet or to change their position to manager skin care risks. There were also communication books which informed staff of key information about people and their appointments as well as handover information which was passed on by the senior nurses on duty. This meant that if staff were not familiar with a person's needs they had easily accessible information about each person in the home.

However, not all agency staff were not given all relevant information about individual needs, nor did they have time to read all of the documentation relating to people's needs. For example one agency member of staff told us that the morning handover had "not been terribly helpful" and another told us they were unaware that one person required a thickening agent in their drinks. They gave this person a cup of tea without the necessary thickening agent which resulted in the person experiencing difficulties. We discussed this incident with the senior managers on duty at the time of the inspection. They proposed to develop an information sheet for agency staff with written details of the care and support people required. This aimed to improve information sharing with agency staff and ensure people were cared for safely.

There were arrangements in place to deal with foreseeable emergencies. We saw that in the front of each person's file there was information about the care of people in emergency situations. The forms showed how to support and evacuate people from the home and

how to keep them safe once evacuated. This showed there were arrangements in place to manage this type of emergency. In other files we saw evidence of planning for medical emergencies such as hospital admissions or end of life care. However one family member we spoke with told us they had not been consulted about decisions that had been made and had been upset by what was recorded. They told us they knew how to complain and would speak with the people concerned.

We saw people engaged in activities such as musical sing along and an afternoon tea party; provided by two activity co-ordinators during our inspection. Other people received one to one support with moving around the home or helping to remain calm and safe during their day. A weekly activity programme indicated a range of activities both within the home and in the wider community. People we spoke with told us about trips to the coast and to other areas of local interest as well as a recent donkey sanctuary visit. This showed that the provider had arrangements in place to support some people's social needs.

However, some people's records showed they had little social stimulation or occupation. For example on Ide unit one person had no social stimulation or occupation for May or August and for June and July one music session was recorded for each month. The records showed that the activities co-ordinator was aware of this. Another person's records show a similar picture with three activities recorded from May 2013 to August 2013. A relative told us they would like to see more social opportunities for their family member as they thought their relative spent long periods alone in their room with little stimulation or social contact, apart from when care was delivered.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider told us about the arrangements they put in place to ensure people using the service were kept safe. They told us about staff induction programmes which included training about safeguarding people from abuse, health and safety and infection control. They told us they routinely updated staff knowledge about safeguarding vulnerable adults to ensure the people received a safe service.

The people we spoke with told us, "I feel safe and secure here"; and "My care needs are done safely, the staff really care". The risk assessments we looked at in relation to people's behaviour and risks to others were up to date and showed the actions staff should take. For example where a person was at risk of constantly falling if they tried to move around the home themselves; the risk assessment stated that a staff member should work with them individually at all times. We saw that a staff member was allocated to work exclusively with that person to ensure their safety.

All of the care workers we spoke with confirmed they had undertaken safeguarding training. We spoke with the provider about future safeguarding training; they told us this training was updated each year. The staff we spoke with said they felt assured that appropriate action would be taken in response to any concerns they raised about suspected abuse.

People who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. We saw that the provider held best interest review meetings with relevant agencies to ensure people remained safe. For example where a person who lacked capacity to recognise where they were or how to return home. We saw that a meeting was held to agree how their safety could be best managed. The outcomes were clearly identified and appropriate door security measures were put in place. We saw that the person concerned was still able to go out on trips but was supported by staff or family members at all times. This showed suitable arrangements had been put into place.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider had not always taken steps to provide care in an environment that is suitably designed and adequately maintained. In one area of the home commode cleaning equipment was inaccessible due to a large amount of equipment being placed on top of the commode disinfector. Some items on top of the commode cleaner had been there for a long time and were stuck to the surface of the cleaner. The room also had a large laundry trolley blocking access to the cleaner and making access to the bins difficult. This meant that effective cleaning of commode pans was not taking place and the equipment was inaccessible. We saw that the provider made immediate arrangements to have the sluice area cleaned and tidied and that the commode cleaner was then accessible.

In one downstairs bathroom and in two shower rooms we found the inappropriate storage of moving and handling equipment such as hoists and wheelchairs which blocked access to the facilities of the room. This meant that the facilities could not be easily used and that where people lacked capacity to understand what room they were in they may think they were in a store room as opposed to a toilet. We raised this with the nurse in charge who arranged for the equipment to be removed immediately.

We saw similar issues in an upstairs unit of the home; however these areas still had equipment in them on the second day of our inspection. We raised this with the acting manager. They told us there was a lack of storage space available in the home where the equipment was needed but that they would raise the lack of storage with the provider to see what alternative arrangements could be made.

In the same bathrooms we found that water temperatures in the hand washing basins were much higher than those recorded on the daily log sheet. Temperatures recorded on one log sheet stated 37deg C; when we tested the water temperature we recorded 46deg C. We raised this with the provider as we were concerned people could scald themselves. They found that a thermometer used to check temperatures was faulty. We were told the home would arrange for new thermometers to be purchased.

They also immediately arranged for the mixer valve to be adjusted to a safer water temperature. Five hours later we found the water temperature in an upstairs shower room was 50deg C. We asked the nurse in charge to isolate the bathroom until the handyman could adjust the water temperature to ensure people's safety. The handyman had not been made aware of this problem by the home's staff; we raised this with him on our second visit and he was able to arrange a repair.

We saw that people were protected from harm through effective health and safety practices in the home. Cleaning materials were kept in locked cleaning trolleys, warning signs were used to indicate cleaning was in progress. However in three bathrooms we found cleaning materials and shampoo in unlocked cabinets. These could present a risk to people who lacked capacity to recognise what these materials were for. The provider may wish to note, not all cleaning or hygiene materials were stored securely.

We saw during our inspection that the main entrance was left unattended for periods of time particularly when the administrator finished their shift. We also saw a rear door to the property which was open throughout our inspection. These meant it was possible for people to enter the building unnoticed placing people who use the service at risk. We looked at the providers' security risk assessment; this stated that the front door would be open between "dawn and dusk" and did not include other entrances to the home. The provider may wish to note that the home was not always secure.

We saw a large amount of equipment used for activities such as games, books and craft equipment in a downstairs area. This equipment was stored on top of book cases and cabinets in an untidy and precarious way making it less accessible to people using the service. For those people with dementia, having equipment stored in this way meant it was difficult for them to find things easily to occupy themselves. The provider may wish to consider more accessible storage of this type of equipment.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not always protected from unsafe or unsuitable equipment.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were not protected from unsafe or unsuitable equipment. In two areas of the home we saw equipment which was not fit for purpose. In the majority of bedrooms where bed rail bumpers were assessed as essential to ensure people's safety we found that the bumpers were damaged with tears or splits to the protective material. Eight bed bumpers were also stained and dirty. In seven of the rooms we looked at where "crash mats" were used, these were torn or ripped. This meant the mats were less effective in cushioning falls. We raised our concerns about the equipment with the provider who agreed they should be changed, they told us they would arrange for replacements to be purchased and would prioritise the order.

We saw that the provider had an auditing system in place to check beds, bed rails and that bed bumpers were fitted correctly. We found that audits did not always include checking all beds or that bed bumpers were in a fit condition to use. Where people were in bed during bed audits their mattresses were not checked. In one of the rooms we looked at we saw that a mattress was no longer fit for use due to a badly damaged protective cover. The mattress was removed and a replacement found.

We received concerns prior to this inspection about the specialist equipment needed for one person on Alphinbrook unit. During the inspection we found that the necessary equipment was in place and was being used competently and effectively by staff. The manager of that unit had put in place weekly checklists to ensure the equipment was functioning correctly and that all of the necessary equipment and attachments were available. This ensured that staff had access to the necessary equipment to meet the person's needs safely.

The provider gave us copies of all recent lifting equipment service work sheets; we saw servicing took place on 1 March 2013 by a recognised service engineer. We saw copies of certificates for the lifts in the home which showed the equipment met the providers' insurance requirements. We saw that the service had an up to date gas safety certificate; that a satisfactory electrical installation certificate had been obtained and that the home was successfully managing the risk of legionella. Fire extinguishers around the home had been checked in May 2013 and most portable electrical appliances had also been checked

within the last 12 months. However some equipment in the upstairs hairdressing room did not have stickers to indicate they had been checked for example the stereo and fan.

There was not enough equipment to promote the independence and comfort of people who use the service. For example where a person had brought their own "tilt and recline" arm chair with them to use in the home; we saw that this was no longer fit to use. The arm rests had been picked apart by the person and had exposed the wooden frame; the seams on the chair back and headrest had split exposing the inner padding. The provider told us they had recognised that the chair was unfit for use but had not been able to identify a replacement chair for the person to use. One of the home's physiotherapists told us a referral was being made for a replacement chair.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to meet people's needs.

During our inspection the majority of visitors we spoke with, the majority of service users; three visiting professionals and about a third of the staff in the home stated that on many occasions there were insufficient staff on duty.

People we spoke with expressed concerns that they sometimes had to wait for long periods before staff responded to their calls. One person told us they could wait for up to 30 minutes for assistance. We were unable to check the call system for how long it took staff to respond to calls for assistance as the system did not have a way of showing old calls. However we observed staff responding to calls in a timely way over a two hour period on both days we visited the home. This indicated that staff responded reasonably to calls for support during this particular time.

One relative told us, "They (staff) are so good but they are run off their feet, that's my only concern", another told us, "I would like to think staff spent time with Mum just holding her hand. But they don't. They don't have time". We saw from the minutes of a recent relative's meeting that staffing levels had been raised as a concern; however relatives praised staff for the care they delivered.

One visiting professional was particularly concerned about the staffing levels and the number of registered nurses on Ide giving an example of one occasion recently when there was one registered nurse on duty for 30 people the majority of whom had nursing needs, including four people with palliative care needs. They told us, "The staff are stretched. If there is only one registered nurse on duty for 30 people I see this as a risk". They told us that people receiving end of life care required additional nursing time and families often required support too. They felt the unit needed more staff in order to be able to sustain the end of life care provided. Another concern was raised with us about insufficient nursing staff on Alphinbrook recently, which resulted in the service being unable to take blood as requested by the GP. Other comments from professionals

included, "Staff are very busy and sometimes appear pressured" and "Staff seem to be stretched at times".

We looked at the staff rota's for a four week period for the three units in the home. We saw each unit had at least one registered nurse on duty at all times of the day and night. On Shillingford unit there were eight care workers on duty in the mornings and seven in the evenings supported by one registered nurse.

Alphinbrook unit, which cared for 15 adults with a physical disability, had five care workers on duty in the mornings and five in the evenings. At least one registered nurse was always on duty. However, from the rotas and speaking with staff we found that this preferred level of staff was not always achieved; on occasion we found that there were four care staff supported by a registered nurse. Staff told us that when the preferred staffing levels were not achieved they found it a struggle to meet everyone's needs in a timely way.

On Ide unit the staffing levels varied. We were told by the unit manager that the preferred staffing compliment was two registered nurses working from 8am to 8pm supported by five care staff in the morning and four in the afternoon and evening. From the rota we could see that these preferred staffing levels had not always been met, sometimes due to short notice of sickness. Agency staff were used where possible to cover absence and on occasion registered nurses were used to cover the care staff shifts. We found that on a number of occasions there was one registered nurse on duty from 2pm until 8pm. We also saw from the rota that over some weekends there was only one registered nurse on duty. On two occasions we found that four staff were on duty from 2pm until 8pm, one registered nurse and three care staff. This meant that people's care needs may not be met.

We looked at the level of needs and dependency of the people in Ide Unit. All people receiving services on the unit had complex needs varying from dementia and neurological diagnosis to physical disabilities and palliative care needs. There were three people with palliative care needs, 16 people who required close monitoring and assistance with eating and drinking to ensure adequate nutritional intake and reduce risks associated with choking. At least half the people in the unit needed the support of two staff when getting up from bed, transferring from chair to chair or when going to the toilet. When looking at other caring tasks which required staff involvement we observed the morning medication round took three and a half hours to complete. This indicated that there were insufficient staff available to meet people's needs in a timely way.

We observed people receiving their morning medication at 11.30am in the morning. Midday medication was being provided by the nurse at 1pm and was dependent on the nurse remembering when they last gave medication to ensure the correct time lapse took place between medications. The medicine administration record had insufficient space to record medication administration times. Breakfast was still being provided to people at 11am and then the same people were being offered lunch at 1pm. Following the inspection we received concerns about staffing levels from a relative who told their family member had not received personal care on one occasion recently until 12.40pm. This indicated that there were insufficient staff available to meet people's needs in line with the way people lived before entering the home.

One person's care plan stated that they needed one to two hourly checks because they could not reach the call bell to alert staff to their needs; however we observed that no checks were made by staff between 9.15am and 12.10pm. On Ide we noted that there was little staff presence or supervision in communal areas in the late afternoon. Staff were busy attending to people in their rooms. We saw that seven people sitting in the lounge were

unsupervised and not monitored for over 20 minutes. We saw that two people became agitated and restless, which disturbed others in the area. On another occasion we found one person attempting to climb out of bed. Staff were busy attending to other people in their rooms and we had to alert them to the risks posed by this person's behaviour.

We asked the senior management team to explain to us how they calculated how many staff were required to meet people's needs. They told us they did not have a method for analysing dependency needs and risk assessments as the basis for deciding whether sufficient staff were on duty. They told us they relied on senior staff in the home to highlight staffing concerns. One of the staff we spoke with told us that staffing levels had not changed in ten years on one of the units. A senior manager told us the provider had been reviewing budgets, dependency levels and staffing as they had recognised the increase in the complexity and dependency of people's needs and conditions. They acknowledged the service had experienced staffing issues, especially recruitment, retention and absence on Ide unit. This meant people were at risk because the home had not reassessed staffing levels even though people's dependency needs had increased.

The home had been without a registered manager for several months. Two visiting professionals felt that this had impacted on aspects of communication and leadership and accountability. A temporary manager had been supporting the home during this period. We were told that a new manager had been appointed and would be starting early in September.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff were able, from time to time, to obtain further relevant qualifications. The staff we spoke with told us about other training they received. One person said, "The induction training was very good." Another told us "We get good access to training including online learning." We saw from the provider's training record log that all employed care staff had attended a basic induction to care course.

We saw training records for staff in the home and saw staff had completed courses in infection control, safeguarding vulnerable adults, health and safety, food hygiene, moving and handling and end of life care as well as other subjects. Training records confirmed that between 90% and 95% of staff had completed training in relation to the above topics.

There was a system in place to alert management to when staff training up-dates were needed. Staff told us and the records reviewed showed that staff had access to training related to people's needs, for example dementia care; wound management; safe management of medication; diabetes; palliative care; care of syringe drivers and feeding systems. This meant that staff had access to a range of training relevant to their role.

We spoke with the senior management team and senior nurses about how they supported staff to develop beyond their induction programme. They told us about providing access to other training such as NVQ (Diploma) courses. Records showed that 46.25% of staff had achieved an NVQ or equivalent. We saw certificates to support what they told us and the staff we spoke with confirmed they had access to on-going training. We saw that the provider had invested in online learning to enable staff to repeat learning to support better care delivery. This meant that staff had the opportunity to gain further relevant qualifications.

Staff told us that they were provided with the training they thought they needed to carry out their roles. They told us about how this training was provided mostly through training DVD's and they were tested about their knowledge following this training. We were told about the practical training in the home for moving and handling.

We spoke with the registered nurses about the training and support they received for maintaining their registration and their continued professional development. They told us

about annual refresher training for basic skills such as moving and handling and infection control which they received from the provider. They told us about the self-directed learning and research they undertook through journals and online websites; and about attending talks and conferences related to their registration. We saw that nurses' registrations were current. This showed nursing staff were supported to maintain their registration.

Some staff told us that they had formal supervision meetings with their line manager and had appraisals annually. The provider may wish to note that we heard that some staff had more supervision meetings with their line manager than others. Staff told us that until recently supervision had been "patchy" because of the absence and resignation of the home manager. We were told by two registered nurses that they had not received any formal supervision for several months. One nurse told they had not received an annual appraisal for two years.

Staff told us about the staff meetings and we looked at the minutes of these meetings. We saw that the most recent meeting had focused on improving practices for record keeping, moving and handling and improving staffs interactions with service users when assisting them in support. This showed that there were opportunities for staff to hear feedback about their performance and a forum for staff to discuss ideas and concerns.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was a complaints system available, however information provided to people about the system was not accurate. Comments and complaints people made were not always responded to appropriately.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. However, the information provided to people using the service and their relatives in the service users' guide was inaccurate. It advised people to complain to CSCI, the previous regulator, if they were dissatisfied with the outcome of the investigation into their complaint. The senior manager told us this would be amended as soon as possible.

The service also provided information about complaints in 'The right to voice comments, suggestions and complaints'. This document explained the process and what people could expect of the complaints system. However, information about relevant contacts had been omitted under the stage two process, the regional stage, where an individual should contact a senior manager if the complaint could not be resolved locally. Under the stage four process, relating to external contacts, the contact details had not been completed to guide people to alternative help. We found that the details of the inspectorate of Wales had been given which would be irrelevant for people using this service. The information about the Ombudsman was also incorrect as it directed people to the Welsh Ombudsman. This meant that people were not fully supported or provided with accurate information about how to make a complaint.

The visitors and people using the service we spoke with told us they knew how to complain and felt able to complain to the staff in the unit. Where complaints were simple they told us these were addressed promptly, however where they were more complicated three people told us the complaints took some time to be responded to. Two relatives told us that their concerns were not always resolved to their satisfaction.

There was not always evidence to show that complaints were recorded or fully investigated to people's satisfaction. We saw from the records that complaints were not always responded to within the timescales described in the policy. For example a visiting health professional had raised concerns in March 2013. They told us during this inspection that they had not received a formal response. The records relating to this complaint

showed that a temporary manager had written a note in pencil in July 2013 on the complaint letter about the action staff should take to address the concerns raised. There was no formal record of any action taken to resolve the concern and no indication as to whether the complainant was happy with the outcome.

Records showed that a complaint raised by one relative had been responded to within the set timescale, but there was no record of whether the concerns were resolved and the whether the relative was happy with the outcome. Similarly we saw that another relative's complaints were placed on file, with a note in pencil about a discussion with the family. However, there was no evidence that the complaints procedure had been followed as there was no acknowledgment letter on file, no evidence of any investigation into the concerns raised, and no evidence that issues were resolved to the person's satisfaction. This meant that there was no effective system of recording or managing complaints.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People did not always experience care, treatment and support that met their needs and protected their rights.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: People were not always protected from unsafe or unsuitable equipment.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not always enough qualified, skilled and experienced staff to meet people's needs.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: There was a complaints system available, however information provided to people about the system was not accurate. Comments and complaints people made were not always responded to appropriately.

This section is primarily information for the provider

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 19 October 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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