Bupa Care Homes (ANS) Limited

Fountains Lodge Care Home

Inspection report

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25 June 2017
26 June 2017
27 June 2017

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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 took place on 23, 24, 25, 26, 27 June 2017 and was unannounced.

Fountains Lodge Care Home is registered to provide accommodation for up to 74 people who require nursing or personal care support. There were 71 people living at the service at the time of the inspection, some people were living with dementia. Fountains Lodge Care Home is a purpose built detached building with the accommodation spread over two floors. Fountains Lodge Care Home is a dementia residential and a dementia nursing home. The ground floor provides support to people who require residential dementia care and the first floor provides support for people with nursing dementia care.

The service is run by a registered manager, who was present on the days of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported to manage the service by a unit manager on each of the two floors.

The management of the two floors, or units, was not the same. People's experience of care was different depending on which unit they lived on. People on the ground floor unit received a good standard of care. However, people living on the first floor, especially those with more complex needs did not receive consistently safe, effective and compassionate care. Some people and relatives spoke positively about the service, but not everyone was happy about the care they received.

People were not always kept safe. When people had accidents these were not always recorded and looked into. When concerns about possible abuse or harm had been recorded the registered manager had dealt with them appropriately. However, not all concerns were recorded so no action was taken. Some people had unexplained bruising, which was not investigated. One person was restricted from moving around the service by staff, often being told to remain seated when they tried to stand and walk around. These restrictions had not been assessed as necessary and had not been agreed to.

Risks to people were not always managed safely and staff did not always follow the guidance in place to reduce risks. For example, some people were at risk of developing pressure sores. They were not always supported to use pressure relieving equipment and other people were not given the nutrition and drinks they needed to help their skin stay healthy. People were referred to health professionals when required, although this was not always completed promptly for everyone. Guidance from healthcare professionals was not always recorded in people's care plans or followed by staff. One person's wound was not dressed as required, resulting in them picking at the wound, which could increase the risk of infection.

People's medicines were managed safely, but there was not always guidance about when to give 'as and

when required' medicines used to reduce people's anxiety or to help them sleep. There was a risk people were being given these medicines unnecessarily or may not be given the medicine when they needed it. Risks to the environment were assessed and managed.

There were enough staff to keep people safe but they did not always have the skills and support needed to meet people's needs. Staff completed training including dementia awareness; however, further training was required for staff to fully understand and support the needs of people living with dementia. Staff did not always receive supervision in line with the provider's policy and staff had not received annual appraisals. The support given to staff varied between the two units. Some managers offered staff mentoring and role modelling, but this was not consistent across the whole service. Staff were recruited safely.

People were asked to give consent when possible and staff had some understanding of the Mental Capacity Act. However, assessments about capacity in people's care plans were not always clear. We have made a recommendation about this.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS authorisations because some people were restricted or were constantly supervised. One person was restricted from standing and moving around and this had not been assessed as being in people's best interests or the least restrictive option.

Staff did not always treat people with dignity or respect their wishes about how they preferred to be supported. Some people had specified what was important to them about their appearance and this had not been followed by staff. The language used by some staff to describe people was not always respectful. Some people went for long periods of time without any interaction or engagement from staff and activities were limited for people cared for in bed or for people with more complex needs. People and their relatives told us staff were kind and people could have visitors whenever they wanted. People told us the food was good and they had a variety of options. The chef aware of people's individual requirements.

Some people's support was based on staff availability rather than their individual needs. People were not all supported to use the bathroom regularly and were left to rely on the use of incontinence pads. Some people's care plans gave staff details about their needs and preferences but others contained less detail and needed updating. Clear and up to date care plans were important as the service was suing a high level of temporary staff from an agency.

There was a complaints policy in place, however, one complaint was not recorded and people told us they did not always feel their complaints had been resolved. We have made recommendations in relation to activities and the management of complaints.

The management of the two floors was not consistent and this had a direct impact on the quality of the care and support people received. Audits had raised some areas of concern which had not been appropriately addressed and other concerns found at this inspection had not been identified. Systems to review documentation had not been effective in identifying inaccurate or out of date information in people's care plans. People were asked for their views about improving the service and these had been acted on, including improving the garden. Some staff told us they were reluctant to air their views as they did not feel listened to.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager had submitted notifications in a timely manner.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

When people had accidents these were not always recorded. Two people had unexplained bruising which had not been investigated. One person was restricted from moving around the service by staff.

Risks to people were not all managed well. Staff did not always follow risk management plans which were in place.

Staff were recruited safely. There were enough staff to meet people's needs.

Medicines were managed safely. However, some people were given medicines to take 'as and when' needed, and there was no guidance in place to tell staff when to administer these medicines.

When concerns about people's safety had been identified and recorded, the registered manager dealt with them appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training but it did not always give them the confidence or knowledge required to meet people's needs.

Staff offered people choices, but did not always have the skills to support people living with dementia to make decisions.

Some people did not receive the food and drinks they needed to remain healthy. Most people told us they enjoyed the food on offer and for some people dining was a sociable and relaxed occasion.

People were not always referred to health professionals promptly. Staff did not always follow guidance received from healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff had built positive and caring relationships with people but this was not consistent throughout the service.

For some people, staff interaction and engagement with them was limited.

People's dignity was not always respected.

People could have visitors whenever they wanted to and were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's support was based on staff availability rather than on their individual needs.

Some people's care plans had been regularly updated to reflect changes in their needs. However, other care plans had not been updated on a regular basis. Staff did not always follow the guidance in people's care plans.

People had the opportunity to take part in a range of activities. There was a limited amount of activities for people with more complex needs.

There was a complaints procedure in place and people told us they knew who to speak to about any concerns. Complaints were not always resolved to people's satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

Inconsistent management impacted on the quality of people's care and support.

Audits were completed on the quality of the service, but had not identified the concerns found at this inspection. Actions from audits had not always been completed.

There was a lack of oversight so some issues had not been picked up or investigated further.

The registered manager showed person centred values, but this

had not cascaded through the service.

Fountains Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection was carried out sooner than we had planned and at short notice following concerns the Care Quality Commission were made aware of by the registered manager.

The inspection took place on 23, 24, 25, 26, 27 June 2017 and was unannounced. The inspection was carried out by a total of five inspectors and an inspection manager, although they were not all there every day. One inspector visited over a weekend to talk to people and their visiting relatives.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). 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. This was because we inspected the service sooner than we had planned. Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with ten people, twelve relatives, the registered manager, unit managers, one member of housekeeping staff, one volunteer, the chef and nine care staff. We had contact with some of the provider's senior managers and staff from the Kent local authority during and after the inspection. We observed staff carrying out their duties, communicating and interacting with people. Some people were unable to tell us about their experience of care at the service so 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.

We looked at 16 people's care plans and the associated risk assessments and guidance. We looked at a range of other records including seven staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits. The provider sent us information during and after the inspection.

During our inspection, we spoke with local safeguarding and commissioning teams about the concerns we identified.

We last inspected this service in August 2015. There were no breaches of the regulations identified at that inspection and the service was rated 'Good'.

Inadequate

Is the service safe?

Our findings

Most people and relatives told us they felt safe at the service, but we found that not everyone was safe. One relative said, "They always look out for my mum, we have peace of mind that she is here." People living in the ground floor unit were supported safely, but people living in the first floor unit did not receive the care and support they needed to keep safe. Staff told us they recognised different types of abuse and knew who to report any concerns to, but they were not always confident that responsive action would be taken by the unit manager.

Before the inspection concerns were raised to the registered manager who had informed the Care Quality Commission and local safeguarding team. The concerns were about people having unexplained bruising and that some staff had been moving people in a 'rough' or unsafe way. The registered manager had taken some action to respond to these concerns. Some people had bruising which was unexplained. Some bruises had been photographed or recorded on a body map, but there were no records to show how the bruising might have occurred or that staff had investigated the causes. When we asked nursing staff about the bruising we were told, "Older people get bruises and they probably just walked into something." The registered manager said they had checked everyone for bruising and recorded this on a body map and said they had no concerns. However, we checked the body maps we found one person had several bruises which could not be explained. The registered manager had not investigated all of the cases of bruising or taken advice from the local authority safeguarding team and therefore, had not looked into the causes of how the bruising occurred and ways of reducing further incidents.

Some people could become anxious or upset and this could lead to them being aggressive towards other people or staff. Staff had raised concerns to the unit manager, about one person's behaviour, that impacted on others and on staff's ability to manage associated risks. The registered manager had followed safeguarding protocols and liaised with the local authority when he had been made aware of incidents. However, we found details of other incidents in people's daily records which had not been reported to the registered manager or investigated as a possible safeguarding risk. For example, one person had pushed another person into a chair, staff had noted a red mark on the person's back as a result of the push, but an incident form had not been completed and the registered manager had not been made aware so this had not been looked into further or reported to the safeguarding team. During our inspection we raised two safeguarding alerts with the local authority due to incidents that placed people at risk of harm and had not been previously reported.

One person did not always have their rights respected and staff restricted their movements without their agreement or any assessment. For example, we observed the person repeatedly tryto stand up from their chair. The person's risk assessment stated they were at high risk of falling from a wheelchair or dining chair. A member of staff was allocated to the person and was told by a senior member of staff to 'make sure the person doesn't get up.' Each time the person tried to stand the member of staff would ask them to sit back down, at times physically moving them back into their chair. At no time did staff try to engage the person or distract them or enable them to stand safely and walk around. When we asked staff why the person could not get up we were told, "They are at a high risk of falls, it needs two staff to support them to walk around

and so it doesn't happen very often due to time constraints."

Staff had not assessed the person's capacity to be able to agree to the restriction of having to remain seated and although the person had a Deprivation of Liberty authorisation in place this did not include physical interventions by staff.

The registered provider had failed to ensure that people were protected from abuse, imposed restrictions and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the ground floor unit of the service had a different experience of care and were kept safe by staff. They told us, "The carers check on me all the time to make sure I am ok." Staff told us they recognised different types of abuse and felt that if they raised a concern it would be addressed.

Risks to people were not always managed in the safest way and staff did not always follow the guidance given in risk assessments. Some people were at risk of falling and relevant risk assessments had been completed. Some people needed to wear suitable footwear to reduce the risk of falls and this was recorded in their risk assessment. Several people who were described to us by staff as being at 'high risk of falling' and needed to wear suitable footwear had bare feet. When we asked a senior member of staff if there was any reason they were not wearing suitable footwear we were told, "There is no reason why they should not have footwear on and I would have expected they should have some on."

One person was sitting in a dining chair after breakfast and fell asleep; when they woke and tried to stand, they fell. Staff supported them from the floor using a hoist. The person's falls risk assessment had recently been reviewed and they had been identified as having 'no history of falls', despite having fallen twice in the previous month. The risk assessment had not been updated to reflect the recent falls and staff did not have the guidance they needed to minimise the risks to the person. The person's change in need and increased risk had not been assessed and mitigated and they continued to fall.

Some people were at risk of their skin breaking down and had risk assessments in place to give staff guidance about how to minimise these risks including turning people who were in bed regularly and recording this. However, staff were not all following this guidance. Some people required staff to help them to change positions to reduce the pressure on an area of skin. People had charts to record when they had been supported to move and to which position. We reviewed charts for two people and found that there were gaps where no records had been made to indicate whether or not people had been supported to reposition. People were unable to tell us if they had been repositioned and although no one had any pressure wounds there was a risk people's skin could be damaged if they were not turned regularly.

Another person's risk assessment showed they should have a pressure relieving cushion to sit on at all times. We saw this person sitting on a dining chair without a cushion for over three hours. When we asked staff about this they told us the cushion "doesn't fit well on that type of chair." After we raised this with staff the person was supported to the lounge area and given a chair with an appropriate cushion. However, later the person was again sitting in a dining chair with no pressure relieving cushion for over two hours. The regional director told us they had checked the person for any issues with their skin, completed a body map and no sore areas were found. However, the pressure relieving cushion that should be used to reduce the risk of sore skin was not always being used.

Some people were at risk of losing weight, and referrals had been made to dieticians to seek their advice. Staff had recently received advice for two people from dieticians; the recommendations said that extra

foods and food supplements should be offered to people in order to maintain a healthy weight. We checked the food and fluid records for these people and found that they were not being offered the food which was detailed in the advice. Staff told us that one person had not been offered extra snacks and some staff were unaware of the advice which had been received. The recommendations from the dietician had not been included in people's care plans so it was not being followed consistently. One person was advised to have high calorie snacks several times a day, along with extra puddings and drinks. The person's food chart showed they had not been offered any extra snacks and were frequently only having half of their main meal.

The majority of people's medicines were managed safely and people received their medicines in the way they preferred. Staff were very patient with people when giving them their medicines. Medicines were stored in a dedicated room which was organised and clean. Records relating to the management of medicines were completed fully and accurately. When people were prescribed medicines to have 'as and when required' (PRN) such as pain relief, there was guidance for staff about what the medicine was for, how the person would let staff know they needed it and how many doses they could have in 24 hours. However, some people were prescribed PRN medicines for them to take when they were agitated, anxious or needed to sleep. There was no guidance in place for some people for these medicines. One person had been given a PRN medicine for 'agitation' on nine occasions between 14 and 24 June 2017. On two occasions there were records to show why the person had been given the medicine. On the other seven occasions the person's daily notes indicated they had been 'settled' and staff had not completed any incident forms relating to the person's behaviour on these dates. There was a risk this person had been given the medicine unnecessarily. The registered manager was unaware that the person had received the PRN medicine and told us they would look into this.

The registered provider had not ensured that people received care and treatment in a safe way. Risks relating to people's care and support were not always adequately assessed or mitigated. Medicines required on a PRN basis were not always recorded properly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people living on the ground floor were managed well. People's care plans were updated as a result of any change in need. Assessments were carried out using specific assessment tools to evaluate whether people were at risk of skin damage, malnutrition and depression. People's records contained assessments of risk associated with self-medication, manual handling procedures, behaviour that may challenge, and falls. Control measures to reduce risks were clearly explained and followed by staff in practice. For example, people were provided with pressure relieving cushions, their walking aids were placed within reach, they were checked regularly at specific intervals and staff recorded these checks. One person, who was at risk of falls, was known by staff to often forget her walking aid. Staff assisted the person to retrieve the aid and walked alongside them to keep them focused on the task. Another person did not like to wear shoes indoors but could be at risk of falling, the staff had suggested the person wore socks with rubber grips on the base. The person was happy with this compromise and was seen wearing their socks throughout the inspection.

The registered manager used a nursing and care needs calculator dependency tool to determine how many staff were required to meet people's needs. The registered manager commented, "The tool identifies a level of need to each person which is assessed during pre-admission and then reviewed monthly where changes would be reflected in the banding." The registered manager completed the spreadsheet every week and the tool automatically calculated the staffing hours required for the service. The registered manager told us that the ratings were then discussed with the unit managers. However, we found that the dependency tool did not give an accurate picture of people's needs or reflected increased levels of needs. Staffing levels did not reflect individual requirements to ensure people were safe. For example, five people had an increase in care needs between November 2016 and June 2017 but the required care hours shown on the dependency tool

remained unchanged. The registered manager told us the dependency tool was only a guide and he could use more staff if needed.

We spoke to the unit manager on the first floor where six people assessed as requiring higher support or nursing care lived. We were told, "Some people have higher needs and they need a little more care around e.g. hoisting, mobility or end of life care." The unit manager said that if people's needs increased this would be flagged up. They said "It varies if people deteriorate or people come out of hospital: people may be poorly some days and better the next." When we asked if the unit manager thought there were enough care hours we were told, "It does balance out, so we have enough staff."

Some relatives told us there did not always appear to be enough staff on duty at weekends. We visited over the weekend and found there were enough staff to meet people's needs. Staff told us it could be difficult to meet people's needs when a large proportion of the staff on duty were new to the service or supplied by an agency. Following the inspection the number of staff on duty was increased; with two additional care staff on duty each shift.

The registered manager and staff told us there had been a number of staff vacancies which had not been filled for some time. The level of vacancies had also been noted in monthly audits by the regional director. This had led to a reliance on staff from an agency to support the permanent staff. The registered manager told us that in the past two months they had been offered some support from the provider to increase recruitment; this included increasing pay for staff to help with recruitment and retention of staff.

Agency staff were not always supported. We observed agency staff being left alone with groups of up to eight people who were living with dementia. There was limited interaction and the agency staff seemed unsure how to engage with people. Some unit managers mentored and inducted agency staff but others did not. Some of the unit managers knew people well and shared their knowledge with the staff; they also role modelled for staff about the best way to keep people safe.

We checked the files for the three most recently recruited staff and four other files chosen at random. Each file had a checklist to sign off completion of each part of the recruitment file, such as Disclosure and Barring Service (criminal records) check, written references, signing off key policies, offer letter etc. The files we reviewed all contained a completed application form, with any gaps in employment accounted for; two references and a completed enhanced DBS check showing that staff were safe to work with people in vulnerable circumstances. Each staff member's identity and nurses PIN numbers had been checked.

Regular health and safety checks of the environment and equipment were completed to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. Water temperatures were checked to make sure people were not at risk of getting scalded. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. Each person had a personal evacuation plan in their care files, describing their degree of mobility, factors to be considered such as confusion or visual impairment, and methods of horizontal or vertical evacuation in case of emergency.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. People and their relatives told us that the staff were caring and friendly and that the food they were offered was good quality. One person said, "We get a good choice, the chef is very nice, she comes and talks to us, she always has a smile on her face." Another said, "Can't find anything bad to say, good staff, they know what they're doing."

There was a training schedule in place for all staff which consisted of face to face and e-learning training. The registered manager told us, "There is a week-long induction and then in the next week behaviour that challenges training is a separate day and nobody works unsupervised until they've been trained. The training is delivered by Bupa's training team." Staff had completed training in core subjects such as fire awareness, first aid, safeguarding and mental capacity in line with the provider's policy. They had also completed additional training related to dementia and supporting people whose behaviour could challenge. The registered manager informed us that there was a dementia essentials course included in all staff inductions. The registered manager and the care and support manager were both 'Person first, dementia second' trainers certified by the University of Bradford Dementia School. The registered manager commented, "We've had to cancel some training recently as we can't afford to let staff leave the shift to attend." We asked who had completed the higher level of training and were told, "The dementia essentials workbook is done by everyone in induction but at present nobody has completed the advanced training." We found that staff did not always have the training and support they needed to ensure that they had the skills to meet people's needs.

Staff sometimes struggled to give people living with more advanced dementia choices in a way they could understand. One person was asked if they would like to go and listen to an entertainer in the garden. The person was disorientated and speaking about collecting their children from school. The staff repeated the question several times, but did not respond to the person's concerns about her children or use any other communication tools such as photograph to help the person to make a decision. When the person did not say yes or no the staff said, "Oh, they obviously aren't interested," and told the person to let them know if changed their mind. Staff did not understand that the person may need support to process and respond to their request.

Agency staff did not always receive an induction when working at the service for the first time. Although the registered manager reported that all new agency staff would work alongside a more experienced member of staff, we observed that one agency staff had been asked to work alone to provide personal care to a list of people. We were later shown an agency induction check list which had been introduced. However, we found that the only section had been completed for one staff and this related to where the fire exits were. There was no information shared about the people they would be supporting and their needs.

On the first floor we observed staff supporting people who were living with dementia. Staff did not always appear confident in engaging with people, especially those whose dementia was more advanced. Approaches to people were inconsistent and some staff gave very limited attention to people, for example, a member of staff was asked to sit with people whilst they ate their breakfast. The staff member sat down at

the table, but did not speak to or engage with people.

Staff had not always received quarterly supervision with their line manager in line with the provider's policy. Only four staff had received supervision each quarter although there had been an increase in the number of staff receiving supervision in the most recent quarter. Staff had not received annual appraisals. We found that some meetings, which were recorded as 'supervisions', were in fact staff signing to show they had read an updated policy, rather than having an opportunity to discuss their role or any support or training they required.

Staff had not all received training related to people's needs and had not all received regular supervision and an appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were referred to health professionals if their health deteriorated. However, action was not always taken promptly and guidance from professionals was not always followed. On the first day of the inspection a person complained of pain, a staff member called the nurse who asked the person what was wrong, then left promising to return. The nurse did not return and did not contact the GP until later in the day when prompted by the person's relative. There had been a delay in responding to that person's health care needs.

Another person had a wound which their care plan stated should be dressed during the day. On the first day of inspection the person, who was living with dementia, removed the dressing. Care staff called for the nurse who removed the remainder of the dressing and said they would return to redress the wound. They did not return to do this for over 40 minutes, the person was scratching at the wound throughout this time, which could increase the risk of infection. On the fourth day of the inspection the person did not have the wound dressed when we arrived. When we asked a nurse why the wound had not been dressed they told us the task had been allocated to the other nurse on duty. We checked again after two and four hours and the wound had not been dressed. On each occasion the nurse stated it was the other nurse's responsibility. When asked the nurses why they could not completed the task they shrugged.

The registered provider had not ensured that people received care and treatment in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the ground floor unit staff were more responsive to people's health needs. A GP had stopped a person's medicine and had requested their blood pressure to be taken twice daily for a week and this had been carried out and recorded. A person who experienced anxiety had a care plan that instructed staff not to overload them with information. Staff were presenting the person with simple options and allowed time for them to respond. Additional care plans were written for a person who wished to have their bed placed against the wall in their bedroom; for people with weight loss, with risk of skin breakdown, and for a person who needed injections twice a day. Staff were aware of people's needs and were able to describe to us how to respond to any concerns about people's health.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. 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.

One person was prevented from leaving and was under constant supervision. Because of this an application to restrict the person's freedom had been submitted to the DoLS office. The registered manager had considered the least restrictive options to keep this person safe. Staff we spoke with were knowledgeable about some of the principles of the MCA and DoLS, and the principles of the MCA were followed.

A person had been assessed as not having the mental capacity to make a certain decision. A meeting had taken place with their legal representatives and a GP to decide the way forward in the person's best interest. This ensured the persons' rights to make their own decisions were respected and supported. People had capacity assessments and best interest decisions in relation to the use of bed rails and other safety equipment that might restrict them.

In all care plans that we looked at, there was a general statement about people's mental capacity regarding their choices and preferences, that stated with the letters L, H and V (for 'lacks', 'has' and 'variable'). Overleaf, there was a list of 14 areas of care needs with these 'lacks, has or variable' statements. This template was issued by the provider who told us previously that these forms would be discontinued as they were not individual enough or related to specific decisions. Some people's care plans had been consented to by a family member and there was no evidence the person signing had the authorisation to sign on the person's behalf.

We recommend the provider review their documentation for recording mental capacity assessments, to ensure that they follow the principles of the Mental Capacity Act.

Staff sought consent from people before they helped them move around or before they helped them with personal care. A person told us, "The girls [staff] are very polite, very respectful, always ask me before doing anything."

People could choose what they wanted to eat on a daily basis and they were asked for their views about the menu which was on offer. On the ground floor lunch was a social event with people enjoying glasses of wine with their meal. Hospitality staff served people their meals and offered snacks throughout the day. One day of the inspection it was very hot and people were offered ice creams and ice lollies, which they seemed to enjoy. People's food was prepared in the correct consistency and information about people's needs and preferences was shared with the chef.

People were weighed monthly or weekly when there were concerns, and referred to dieticians when they had a reduced appetite and weight loss. Two people had been referred to dieticians who had made specific recommendations about offering snacks little and often, and about food fortification. This was effectively implemented in practice as the chef had been appropriately informed and staff were aware of these requirements during staff handovers. These people were provided with a nourishing drink and double cream served on their dessert at mealtime. One relative told us, "The staff encourage her to eat little snacks between meals, she likes toast." Food and fluid intake charts were monitored appropriately.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff were caring and knew them well. One person said, "They seem to know what I like." Relatives said, "The manager (ground floor) is very good, she really cares and always have time to talk to us even when she's busy."

Some staff did not always treat people in a dignified and respectful way. One person, who was living with dementia, came out of their room in their underwear. A member of the housekeeping staff steered the person into the dining room area which had a number of people in it. A member of the care staff did then respond by covering the person or supporting them back to their room.

A visiting health professional informed a nurse on the first floor that they had found faeces on a person's foot whilst treating them. The nurse responded by saying, "Well they had a shower this morning." Staff on the first floor referred to people as 'walkers' (physically able), 'doubles' (people who need two staff to support them to move) and 'wanderers' throughout the inspection which was disrespectful.

We observed people being moved by staff using a hoist. Whilst staff did this safely they did not always take into account people's dignity. When ladies were wearing skirts their dignity was compromised by the hoist straps that went between their legs. Staff did not respond to this. Staff moved people once they were in the hoist to the chair rather than bring the chair under them; this caused them to swing in the hoist which could make people anxious. Some people's care plans stated that certain elements of their personal care and appearance were very important to them. However, we found that these details were not being taken into account when supporting people. For example, not supporting people to remove their body hair or to wear certain items or lipstick.

One person had been incontinent and their clothing was wet. An inspector pointed this out to staff, and three staff interacted with the person, but did not offer to support the person to change. Over ten minutes passed before they were supported to get changed which meant that their dignity and comfort was undermined while they remained in soiled clothing.

One person's care plan showed they preferred to be seated in a comfortable chair in the lounge. However, the person was seated in a chair in the dining room for over four hours. When we raised this with staff we were told, "It's not good enough is it." Staff then supported the person to the lounge area. Later in the day the person was supported to go into the garden, but only as a result as a prompt from an inspector. Some staff members sat with people for long periods of time and made no attempt to interact with them. On the last day of the inspection additional care staff were available. As a result interactions with people were more frequent and people were more engaged.

People were not always treated with respect or dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff obviously knew people well and interacted in a caring, warm way with them. We saw staff

speaking to people in a respectful way and some staff knelt to be at a person's level when speaking to them. Staff offered people empathy and physical reassurance when they were anxious, by holding their hand or giving them a hug. Staff went to fetch a pressure relieving cushion for a person who wanted to sit in a chair outside. One person living with dementia was taking time to move from one area to another and staff were very patient, encouraging them over a long time to put a foot in front of the other. One person was offered a 'pit stop' between their room and the dining room on a chair; staff chatted to them as they rested before encouraging them to continue walking.

The unit manager on the ground floor reassured a person who was very anxious, feeling lost and who wanted to know why they were there. The unit manager offered lots of patience and kindness. When the unit manager had to leave to tend to another person, she asked a care staff to take over so the person would not be left alone. The care staff reminded the person of their last conversation about the person's golfing and childhood abroad and the person appeared reassured.

The registered manager visited people at mealtime. He knew each person by name and they knew him. He spoke with people and spent time sitting next to two people. People had walking frames which were decorated and personalised. Staff told us, "It helps them locate their own, it is important."

Visitors were welcome in the service and there were no restrictions as to when they could call. Relatives told us they were made to feel welcome when they visited, and were offered refreshments. Visitors joined in with activities which were offered and some spent time with their relative or friend in the garden area. There was a play park area in the garden for visiting children which people could see from their window. Staff understood the need for confidentiality; they moved to quiet areas to talk about people and lowered their voices. Records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. People told us staff were responsive to their needs and said, "The staff are always lovely and would do anything if I ask." Relatives told us, "The carers are very good, they come straight away if you need them" and "The activity co-ordinators are absolutely brilliant, I have never seen my loved one smile so much."

However, we found that care was not always responsive to people's needs. We did not see anyone living on the first floor being offered the opportunity to use the toilet. There was a reliance on incontinence pads. People were not supported to have their pads changed when needed but rather at set times of the day. One person's care plan showed they were able to use the toilet if regularly prompted. However, staff told us the person used incontinence pads so they did not support them to use the toilet regularly. Staff told us that at times there was a shortage of pads available, so people sometimes used pads belonging to someone else which may not fit or provide the correct absorbency. Using incontinence pads rather than being supported to use the toilet could increase the risk of skin damage. At the time of inspection no one at the service had any skin damage.

Before moving into the service people, with their loved ones if appropriate, completed an assessment with the registered manager which formed the basis of their care plan. Some people's care plans contained useful information for staff, for example, one person could ask staff a number of questions, there was details of the questions and suggested responses for staff. However, people living with dementia did not have care plans related to supporting them with living well with dementia. There was limited information about the type of dementia they had been diagnosed with, how this may affect them and how staff should support them. People's care plans were not always updated as their needs changed. There was a high number of new staff and agency staff, so not updating people's care plans could lead to a risk that people would not receive the care they needed or in the way they preferred.

The registered manager and the provider had failed to maintain accurate and complete records in relation to each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were personalised and person-centred. They showed what people liked, disliked, and their preferences. A 'Lifestyle' care plan detailed their history, past occupations and interests, a family tree, important memories and people who were of particular significance to them. One person liked cards, dominoes and reading sport newspapers. Another person 'tended to feel the cold' and liked a few blankets in bed; another person liked their bedroom door closed at night.

There was an activities programme including music, bowls, and entertainers, thoughts of the day, gardening, quizzes, art and garden walks. 'Assisted feed' was often recorded as an activity, this is not an activity in is an element of people's support. People who were able to take part in the activities told us they enjoyed them. However, we found very limited activities for people with more advanced dementia. There were no sensory based activities offered, for example 'twiddle muffs' They are a knitted muff with items

attached so that a person living with dementia can twiddle with their hands. There was some evidence of one to one visits to people in their rooms, but this was infrequent. People's care plans often detailed their hobbies or interests but these were not always reflected in the activities they were offered. For example, one person's care plan showed they liked to go walking, and the person was seen throughout the inspection walking up and down corridors on their own. We did not see staff offer the person the opportunity to go out for a walk and their daily records showed they had not been outside the premises for a walk in several months. The people who were living with more advanced dementia were unable to tell us if they had enough to do. Our observations showed a lack of interactions and opportunities for meaningful activity. For example, relatives of people told us their loved one 'loved gardening' but people on the first floor unit could not access the garden independently and had limited opportunity to take part in gardening.

We recommend the provider reviews the activities programme to ensure it meets the needs of people living with dementia.

Complaints were not consistently used as a learning opportunity to improve the service. There was a log in place for recording complaints. We viewed ten complaints in the last 12 months. The most recent complaint was from March 2017 and was in relation to poor response time to call bells, a breakdown in communication and a poor dining experience. The complaint was recorded on the log as 'unresolved'. We spoke to the registered manager who told us, "Because I couldn't resolve the complaint I referred it to safeguarding. We had a case conference last week and no abuse was found." The complaints log had not been updated to reflect this. Another complaint from later in March 2017 had not been entered on to the log. The registered manager had written to the complainant to inform them that an investigation would be conducted and a referral to safeguarding and CQC would be made, but no outcome was recorded.

We reviewed other complaints and found that a complaint made in October 2016 had not been resolved appropriately. The complainant had raised several issues, including missing items and concerns about staffing numbers on a specific day. However, in two separate responses to the complainant a full explanation had not been given. There was no outcome of an investigation into concerns about staffing levels on the day in question and some items had not been recovered or accounted for. We asked the registered manager for an outcome or further learning from the complaint and were told that it had been escalated to a senior manager to investigate. We reviewed the response from the senior manager and found that the complainant still had not received a full explanation. There was a display in the staff rest area highlighting complaints received, actions taken and lessons learned.

We recommend that the provider follow their complaints procedure and ensure all complaints are recorded and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

Although people and relatives told us the registered manager was approachable and accessible, the registered manager did not have a clear oversight of the whole service. Some staff on the first floor unit told us they did not always feel supported or valued and that they were not always listened to if they expressed concerns to their unit manager, some staff had reported concerns to the registered manager which had been acted upon.

The management of the two floors was not consistent and this had a direct impact on the quality of the care and support people received. For example, one person on the first floor called out to the unit manager as they passed the lounge, the unit manager did not respond, when the person called out to them for the second time the unit manager stayed by the lounge door and told the person to speak to the care staff in the room. On the ground floor when people called out to the unit manager they stopped and spoke to people. If they needed a member of care staff to take over from them, they ensured the care staff knew what the person needed and were confident to support the person before leaving.

Staff told us they were not always supported or listened to by the senior staff. Staff asked the unit manager or nursing staff for support several times during the inspection, on several occasions the unit manager or nurse said they would be back to help but did not return for long periods of time. In the ground floor unit staff appeared more confident when supporting people. The unit manager worked closely with new staff acting as a role model and mentor. One staff member told us "We get good training here, and the unit manager is smashing, very supportive, the manager too, we can talk to him about whatever, he will listen."

Staff told us it was difficult to provide high quality of care when having high levels of agency staff. During the inspection we saw the permanent care staff working very hard to meet people's needs while supporting new or agency staff. The unit manager and nurses did not always work alongside care staff and did not always offer support even when asked directly by care staff. The nursing staff did not work as a cohesive team and communication was not effective in making sure people's needs were met. For example, one person had recently been prescribed supplements to help them maintain their weight, we asked one nurse when these would arrive and were told they would probably arrive in a week or so. The other nurse on duty then told us that the supplements had already arrived. There was a risk the lack of communication between nurses would impact on people's care and support. Other staff told us they were well supported by both the registered manager and unit manager.

The quality monitoring systems for the service had failed to identify where there had been a failure to meet people's needs. This was particularly in relation to the first floor and we found that clinical governance systems were not effective. These included a number of audits completed by staff at the service, the registered manager and regional directors. After the inspection the provider told us that previous audits had highlighted a number of issues at the service and as a result a 'home improvement plan' had been implemented and as a result improvements had been made. However, monthly audits had highlighted that care and wound plans for people on the first floor had not been updated regularly since January 2017, but this had not been addressed. The registered provider had not ensured that there was adequate overview

and supervision of nursing staff to ensure that people's needs were consistently met.

Not all audits had been effective in highlighting shortfalls at the service. We asked how the registered manager monitored that people had enough to eat and drink. We were told that there were daily diet sheets that were completed and that the registered manager and clinical team would look at weight loss or an increase in infections. The weekly clinical risk meeting had a section on nutrition and hydration and a person was highlighted as being at risk of weight loss and action had been taken. However, not all audits had been accurate. One person had been seen by a dietician two weeks before our inspection and placed on a special fortified high calorie diet. The clinical risk records did not highlight this need and the person had not been consistently receiving the recommended diet. We raised this with the registered manager who told us, "With [person] it should have been picked up on the clinical risk meeting but it was not. There's no check to check the person checking."

There had been ongoing safeguarding issues; there had been clusters of concerns and safeguarding incidents raised since the last inspection. These issues were addressed appropriately at the time by the registered manager but the resulting improvements had not been sustained. For example, there had been a number of incidents of people hitting each other. The incidents continued, there had been no changes to people's support to try to reduce the number of incidents. There had been some incidents that should have been reported to the local safeguarding team for advice or investigation. Not all of the incidents had been reported. Incidents of unexplained bruising had been recorded but there had been no investigation or analysis into how or why they had occurred and what may reduce the likelihood of further incidents.

Staff did not always report concerns or incidents and this had not been identified by the management team. Documents from the first floor were not always completed in full. We attended a daily meeting where senior staff attended to share information and the nurse from the first floor gave documentation to the registered manager, stating it was completed in full. However, when the registered manager checked, there were gaps in the information. The registered manager told us, "I'm not a registered general nurse so I do rely on the nurses in the service to lead on the clinical elements of care." The registered manager was a registered mental health nurse with significant experience in managing large establishments. He was supported by a Clinical Services Manager who was responsible for any clinical elements of care.

Records relating to people's care were reviewed monthly. However, we found that where care plans had been reviewed changes to people's needs were not always recorded. For example, one person's care plan recorded 'no changes needed'. However, we found that the person's daily notes showed the person was receiving a higher level of care that was shown in their care plan. When we spoke to the member of staff who had reviewed the care plan they were unaware of the changes in the person's care needs.

Risk assessments had not all been reviewed, for example, when a person had increasing amounts of falls. Records relating to some people's medicines had not all been checked to make sure they were accurate and up to date. The provider's audits had not picked up that not all staff had received the training they needed to meet people's needs and that staff had not all been supervised and appraised. The provider had not identified that there were times when people were not always treated with dignity and respect. The provider had not identified that not all complaints had been recorded and resolved to the complainant's satisfaction.

People were asked for their views about the service and the providers responses were displayed in the units in a 'you said, we did' format. For example, people had said the garden needed to be tended more often, the registered manager had increased the time the gardener worked at the service and people had said they did not enjoy the gammon on the menu so this was replaced with chicken supreme which appeared to be more popular. Staff had been asked their views, but told us they had previously made complaints which were not

responded to and as a result were unwilling to raise concerns.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. Not all risks had been assessed and mitigated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of updates in legislation that affected the service and communicated these to staff effectively. The service's policies were appropriate and clear for staff to follow when they needed to refer to them. The registered provider had met the requirements to notify the Care Quality Commission of any significant events that affected people or the service.

The registered manager and provider took action during the inspection as a result of the concerns we raised. An additional four care staff were placed on duty to support the first floor unit. Staff told us, "We are able to meet people's needs much more effectively today with the extra staff but we know it won't last." We asked if the increased staffing levels was permanent and were told that the plan was to have two additional carers on the first floor moving forward. Unit managers from other Bupa services had been brought to the service to observe practice and support staff. A regional support manager attended the service before the inspection to support the induction of new and agency staff. As a result of the concerns we raised their role was expanded to address the risks to people and to improve the quality of the care people received.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect or dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not all received training related to people's needs and had not all received regular supervision and an appraisal.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that people received care and treatment in a safe way. Risks relating to people's care and support were not always adequately assessed or mitigated. Medicines required on a PRN basis were not always recorded properly.

The enforcement action we took:

Warning notices to RM and provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure that people were protected from abuse, imposed restrictions and improper treatment.

The enforcement action we took:

Warning notices issued to RM and provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. Not all risks had been assessed and mitigated

The enforcement action we took:

Warning notices to RM and provider