DFB (Care) Limited

Palm Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Palm Court Nursing Home provides nursing care, personal care and accommodation for up to 53 older people living with dementia. There were 30 people living at the home during the inspection; they were all living with dementia and required assistance with looking after themselves, including personal care and moving around the home safely. Some people were living with behaviours which may challenge themselves and/or others.

This inspection took place on 26 and 27 September 2016 and was unannounced.

The service has not had a registered managed since January 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been appointed nine weeks before this inspection and they informed us they would be applying to register with the CQC as the registered manager.

Palm Court Nursing Home consists of two older properties at the front that have been converted to provide bedrooms on the ground and first floor, some with en suite facilities, communal bathrooms, three lounges and a dining room. An extension to the rear has bedrooms with en suite facilities on the ground floor and the building has been further extended to link up with a newly converted property on the side of the original home. This provides bedrooms, with en suite facilities on two floors, communal bathrooms, a dining room and a large lounge. The provider wants to extend the number of people that can live in the service but this has not yet been registered with the commission.

The quality assurance and monitoring system was not effective. Improvements had not been made with regard to staffing, training, activities and personalised care; some of these were continuing breaches of regulations and, the provider's auditing system had not identified areas that required improvements.

The manager and staff were open regarding their concerns about staffing at the home. They had realised this meant the care and support provided was task orientated at times and did not consistently take into account the needs of people living with dementia. Some activities were provided and people enjoyed spending time with staff. However, these were not personalised to each person, and there was no evidence they followed current guidance for best practice.

Risk assessments had been completed as part of the care planning process. However, they did not include all the information needed to plan care or relevant guidance for staff to follow to meet people's individual needs. There were systems in place for the management of medicines, but nurses did not always follow appropriate guidelines.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which

applies to care homes. Staff had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards, and the manager understood the process for applications for DoLS. Some staff had attended safeguarding training and they knew how to keep people safe and protect them from abuse. People said they were comfortable and relatives told us they thought people were safe.

Staff supported people to make their own decisions about the food they wanted. People thought the food was good and choices were available. Relatives and friends could visit at any time, they were made to feel very welcome and said the staff were very good.

People used bedrooms in all parts of the home; some preferred to remain in their rooms or were supported to do so because of their health care needs, while others were assisted to move into the large lounge in the new extension.

A complaints procedure was in place. Staff addressed issues they could deal with at the time and referred other concerns to the registered manager or provider.

Staff felt supported by the manager, they were included in discussions about how the service could be improved and felt like active members of the team.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found four 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 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 consistently safe.

There were not enough staff working in the home to provide safe care and treatment.

Staff used unsafe lifts to assist people, although they had attended moving and handling training and understood this was not safe.

There was a system in place for the management of medicines, but there were no clear processes for addressing gaps in administration records.

Risk to people had been assessed, but were not effectively managed as part of the care planning process.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

The premises were well maintained and people had access to all areas of the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received up to date training to make sure people received the care and support they needed.

People were provided with food and drink, but there was no clear evidence that this supported them to maintain a healthy diet.

Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and understood people's capacity to make some decisions

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

The service was caring.

People were treated with kindness, they were respected and their dignity was protected when staff provided personal support.

Staff knew people well and ensured they offered support and care.

Relatives were able to visit at any time, and were made to feel very welcome.

Is the service responsive?

Inadequate

The service was not consistently responsive.

The provision of activities varied, they were not personalised and did not promote people's health and wellbeing.

People's needs had not been appropriately assessed and care and support was not personalised to meet their individual needs and preferences.

People were given information on how to raise concern or make a complaint, and relatives felt their concerns would be addressed.

Is the service well-led?

Inadequate

The service was not consistently well-led.

There had been no registered manager since January 2015 and this affected the services provided and impacted on meeting people's care needs.

The quality assurance and monitoring system was not effective. There were outstanding breaches of regulations and areas for improvement had not been identified.

There was no system in place to obtain feedback from people, their relatives or external health and social care professionals to ensure that the support and care provided was what people needed and wanted.

Staff felt supported by the manager and more involved in how the service was developing since their appointment.

Palm Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on the 26 and 27 September 2016 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we hold about the home including previous reports, complaints and notifications. A notification is information about important events which the home is required to send us by law. Before the inspection, we asked 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. The provider submitted a PIR after the inspection.

We contacted the local authority and commissioners of care for Palm Court and were informed that the local authority continues to support the home to improve the services provided.

As part of the inspection we spoke with the all of the people living in the home and five of their relatives. We spoke to ten staff, which included the cook and manager.

We observed staff supporting people and reviewed documents; we looked at the six care plans, medication records, four staff files, training information and some policies and procedures in relation to the running of the home.

Some people who lived in the home were unable to verbally share with us their experience of life at the home, because of their dementia needs. We spent time with people in their own rooms and in the lounge and, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our inspection on 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to the safety and security of the home and staffing levels. We carried out a focused inspection on 15 June 2015 as we had received information that there were not sufficient staff to keep people safe and we found improvements were needed in relation to staffing levels. The provider sent us an action plan stating improvements would be completed by 12 August 2015. At this inspection we found the provider met the regulation regarding security and safety of the premises. However, we found the provider was not meeting the legal requirements in relation to staffing; which was a repeated breach from the inspection of 30 December 2014 and 12 January 2015 and, the requires improvement from the focused inspection of 15 June 2015 had not been improved. In addition, we identified other areas where improvements were needed.

People said they were comfortable. One person told us, "It is a nice place to be" and, "I'll spend the rest of my life here. This is good enough for me." Relatives said that people were safe and the staff looked after them well. However, they also told us there were not always enough staff working in the home. Staff said they could provide a better service for people if there were more staff, "We could do with one more person on in the morning" and, "The manager is trying to get more staff, which will be much better."

On the first day of the inspection staff continued to give out breakfast until late morning. This was very close to lunch and people were not offered a mid-morning hot drink because, "We were too busy." A relative said breakfast was quite often late; their family member would have preferred to have breakfast in their room before they moved into the lounge. They said this meant they probably didn't enjoy or eat their lunch. Staff said, "We need a minimum of eight staff in the morning just to make sure people are safe and they can have breakfast at a reasonable time."

People sat in the large lounge in the new extension staff said, "We use the large lounge now, the last manager moved everyone here from the other lounges because there wasn't enough staff and people weren't safe." There were long periods when only one member of staff was in the lounge, and even when other staff were available there was very little communication between people and staff. People were not asked if they were comfortable or needed assistance in addition to meals. For example, one person sat at a dining table for over an hour without any interaction from staff; they then attempted to stand to leave the lounge, but had to wait twenty minutes for assistance from staff.

Senior staff said, "The recent admissions have stretched us a bit; just giving out medicines takes longer because people are in rooms in both buildings." "If the manager is not here there is only one nurse, we answer the phone, deal with GP or other referrals and visitors, give out medicines, which means we are spread too thinly." Staff told us when the activity person left they had not been replaced and staff had been providing activities since then. One said, "We really don't have the time unless there are more staff on duty and it is even more difficult at weekends when there is generally even less staff." Another told us, "We need more staff if we are going to look after people properly, like spend time just sitting and chatting to them, especially those who stay in their rooms." Records were kept of staff checking on people who remained in

their rooms, but these did not show how long staff spent with people." Staff told us, "We don't have time for one to one support." There were not enough staff on the first day of the inspection to provide safe care and treatment and this impacted on the time staff spent with people and the support provided.

On the first day of the inspection we were told that one of the night staff had gone off sick and a replacement had not been found, which meant some of their work had not been completed by the time the day staff started. This included cleaning the lounge floor and the chairs. However, they had supported four people to wash, dress and sit in the lounge. Staff told us they usually supported each other if staff went off sick, but this was not always possible and agency staff were rarely used. The provider had a tool to assess the staffing levels needed to meet people's needs, although the manger said they had not used this. The manager said they were aware that more staff were needed, they had actively been recruiting care staff and nurses and when relevant checks were completed the staffing numbers would increase.

The provider had failed to ensure that people's needs were met, as there were not enough staff working in the home. This is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they would not admit people to the home until there were enough staff, with the skills and understanding to provide appropriate support and meet people's needs. However, despite the staffing issues two people moved into Palm Court at the time of the inspection.

Senior staff said, "We don't have the time to observe other staff to make sure safe practices are followed." Staff failed to follow current guidance with regard to supporting people who needed assistance to move around the home safely. Staff told us they had attended moving and handling training; the trainer said all staff had completed this and were required to follow the guidance when assisting people. We saw one member of staff used appropriate support to help one person to stand up and some staff explained what they were doing when using a hoist to transfer people to and from armchairs. Staff verbally demonstrated an understanding of how to transfer people. For example, staff told us that lifting or supporting people by pulling them up, or steadying them, under their arms was unsafe and put people at risk of injury. However, some staff used this unsafe lift when assisting people to stand, walk, transfer and change position in their chairs. Staff used a handling belt, designed to support people who can stand but may be unsteady, to lift a person up from a wheelchair and transfer them to an armchair. Staff had not followed current guidance for assisting people to move around the home safely, which meant people and staff were at risk of harm or injury.

The provider had failed to ensure that staff had the skills, understanding and expertise to provide appropriate care and support for people living with dementia and, that they were supervised and supported to provide safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had been reviewing the care plans, including individual risk assessments to keep people safe and, a one page risk assessment had been introduced since the last inspection. These recorded people's specific needs, including the risk of falls, pressure damage and weight loss, with guidance for staff to follow to support people to reduce the risk. However, discussions with staff showed that they did not have a clear understanding of people's needs, as recorded on these forms, and this could affect the support provided and put people at risk of harm. For example, one person had a weakness on one side of their body following a stroke; staff were not aware of this and said they had not had a stroke.

Recruitment procedures were in place to ensure that the provider employed people who were suitable to

work at the home. The documentation included completed application forms, employment history, interview records, references and Disclosure and Barring System (police) checks. However, some of the references were provided by friends and work colleagues rather than previous employers, which meant there may not be sufficient evidence with regard to their employment history, skills or understanding of the support needs of people living with dementia. The manager said they had contacted the previous employers by phone, but there were no written records to support this.

The provider had a plan to deal with an emergency; a contingency plan was in place to move people to a nearby home if people were at risk and personal emergency evacuation plans (PEEPs) had been completed for all but the most recent admission to the home. We found some of the information recorded was different from care plans and risk assessments. For example, two risk assessments stated people used walking aids, a stick or a zimmer, and the assistance of one member of staff to move around the home. In the PEEP it stated these people were immobile and a hoist and wheelchair would be needed to assist them to move to a safe area. Staff may not use the most appropriate equipment to support people during an emergency if the guidance for them to follow was not correct. The manager said they would review the records to ensure they reflected people's needs.

As far as possible people were protected from abuse. Staff said they had received safeguarding training and others said it had been arranged. They demonstrated an understanding of abuse and described the action they would take if they had any concerns. All staff told us they would report any concerns to senior staff or the manager. Safeguarding policies and procedures were in place and staff said they had read these. Staff knew about the whistleblowing policy and said they felt confident about raising any issues they may have with the manager.

Staff wore a tabard to inform people, visitors and other staff that they should not be disturbed while they gave out medicines. We observed, at lunch time on the second day that, they were given out to people individually; staff locked the trolley as they assisted people to take their medicine and the MAR was signed immediately afterwards. Each person had a MAR which stated what medicines had been prescribed and when they should be taken. A photograph had been attached to the front, although these had not been done for people recently admitted to the home, with contact details of their GP and any allergies. Medicines were stored correctly. Medicines were kept in a fridge when appropriate and the temperature was checked daily. The medicine trolleys were kept locked and secure.

There were systems in place to support people if they refused to take their medicines. GPs had been contacted and records showed they had agreed to medicines being given covertly, if they had been assessed as necessary for a person's health and wellbeing. This meant medicines may be added to food and given without the person's knowledge. Although staff said people were offered the medicines first and only when they refused were they given them with meals.

There were policies and procedures in place for the administration of medicines on an 'as required' basis (PRN) such as paracetamol for pain. Staff were aware of the PRN medicine policy and explained that these medicines were recorded, with details of why they were given and how often. Staff said if there were any concerns the person's GP would be contacted. Records were kept of prescribed creams and ointments on the MAR. These were administered by care staff when they supported people with their personal care and they informed the nurse in charge who signed the MAR to evidence they had been applied.

The manager told us that to ensure the environment and equipment used in the home was safe and suitable they had carried out an audit of the rooms, to identify if any improvements were needed. A maintenance person had been appointed one week before the inspection and the manager said any improvements or

repairs were recorded in the maintenance book and signed off when completed. The manager said a legionella check had been completed to ensure the safety of water supply and checks had been arranged for the lifts. Fire tests were carried out weekly and the staff said they had attended fire training or it had been arranged.

Requires Improvement

Is the service effective?

Our findings

At our inspection on the 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to the provision of relevant training. The provider sent us an action plan stating improvements would be completed by December 2015. At this inspection we found the these improvements had not been made, this was a continued breach and, we identified other areas where improvements were needed.

A training plan was not available to review what training has been provided, to ensure staff have the skills and understanding to support people living with dementia. Three staff said they had not attended specific training, such as dementia awareness. The services at Palm Court were promoted as specialist provider for people living with dementia, and relevant training was essential to enable staff to provide appropriate care. However, we observed some poor practice with regard to supporting people living with dementia. Staff placed seven people in chairs along the edge of the lounge. This meant they faced a large open area, with no activity during the first day of the inspection; people were isolated despite sitting next to other people and they were in the same position until after lunch, when one had a visitor and two were assisted with personal care. This was not reflective of specialist dementia care.

Meals were not provided in a way that supported people to have a relaxed and sociable experience, although staff said mealtimes were very important. Staff had not asked people where they wanted to sit for lunch, such as at the dining tables in groups. Communication between people and staff was very limited as staff asked people what they wanted to eat and provided the meals and drinks they wanted.

Staff did not consistently communicate with people when they assisted them to move around the home or when people needed assistance. For example, staff did not explain to two people what they were doing when they moved them using a hoist from wheelchair to armchair in the lounge. These people were not reassured as they were lifted up in a sling, moved across and placed on their chairs. This showed that staff did not have the necessary knowledge and understanding to fully support people living with dementia; they had failed follow current guidance such as treating 'people as equals, ensuring they remain in control of what happens to them' in line with Social Institute for Excellence (SCIE) 'Dignity in Care'.

The provider failed to provide appropriate training for staff to support people living with dementia. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the staff said they had attended some training, including continence, equality and diversity and moving and handling. One said, "I know a lot of training has been arranged for us to do, which will be good." The manager said they were aware that some staff had not attended or updated their training and they had been reviewing training records to develop an up to date training plan, "Which will ensure that all staff have attended appropriate training so that we can meet people's needs and provide the support they need." Whilst the manager had significant plans to ensure staff attended training, the reality for people living in the home was that had not consistently received the care and support they needed.

Staff told us they had completed induction training when they first started work at Palm Court. They said they worked on a supernumerary basis with more experienced staff as they developed an understanding of people's needs and how to support them. In addition the care they provided was observed and assessed by senior staff, although there were no written records to support this. One told us, "I have been working in the lounge assisting people with drinks and meals and when people need support with personal care I have been watching other staff and helping them. I have done the moving and handling training and there is lots more lined up." The manager said the induction training was not currently in line with Skills for Care, a training programme that usually takes three months to complete. To improve this they had been looking for a training provider to introduce a training programme that linked induction with on going professional development and they planned to start this with new employees and, two staff told us they had already signed up to do national vocational training. The proposals for staff training would offer staff opportunities for professional development, but the reality for people at the time of this inspection was that staff did not understand their needs and therefore people's needs had not been met.

The manager said from the records he had viewed supervision had not been consistently provided for staff in recent months. They had started a supervision programme with senior staff, including night staff, which in turn would be responsible for supervision of care staff. Nurses said they had had one supervision with the manager, which gave them an opportunity to discuss issues like staffing and they felt supported to express their concerns. Care staff told us, "I haven't had any supervision" and, "I think it has been some months since supervision." The manager told us it would take some time to provide supervision for staff, as the number of staff increased, but they felt it would work well when up and running. At the time of inspection it was not running and therefore staff were not supported to identify training needs they may have, or poor practice, and take appropriate action.

The manager and some staff had attended training and had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been completed in two of four care plans we looked at. These had identified that people were unable to make safe decisions for some aspects of the care provided, such as forgetting to take medicines and records showed that nurses were responsible for giving out prescribed medicines. DoLS safeguards protect the rights of people by ensuring if there are any restrictions to freedom and liberty, these are authorised by the local authority following a best interest meeting; to ensure decisions are based on protecting the person from harm. The provider had previously applied for DoLS for the locked front door and the manager had made additional applications as they identified people who may be at risk. For example, some people were at risk of falling out of bed and applications had been made for the use of bed barriers to reduce the risk.

Staff said people could make decisions about aspects of their day to day support, "Even when they cannot speak to us they can let us know with their body language and expressions." "If they can do something we let them" and, "People should make choices about everything, if they don't want to get up we leave them and go back later and ask again. It is up to them, we should fit in with what they want to do."

Relatives said they had been involved in discussions about their family members support needs and they knew care plans had been written. Records showed that people had support from relatives or other representatives and a number of relatives had power of attorney and made decisions on people's behalf. One member of staff said, "Which is essential really as they know them much better than we do." Two relatives had not yet seen the care plan and one relative had signed to show they had read the plan and given consent for photographs and the use of bed barriers and were very involved in decisions about the care staff provided.

People told us the food was good. One person said, "We can have as much as we like," another person told

us, "The food is super." Relatives said there was always a choice for each meal and, "It looks good." They also told us breakfast was often given very late in the morning, which meant people did not always want their lunch. Staff said they had a good understanding of people's needs.

People were offered choices at each meal and the chef had a good understanding of people's preferences and dietary needs, such as diabetic diet, soft or pureed meals. They said people can have what they want and one chose to have sandwiches rather than a cooked meal at lunch time. Several people were assisted to eat their meals, staff sat next to them; support was offered at their pace, eye contact was maintained and staff spoke to them asking if the food was nice and if they wanted some more. People were weighed regularly and GPs were contacted if they lost weight for a referral to the dietician. Full fat cream and milk were added to meals to increase calories and fortified drinks were provided if people were at risk of losing weight.

People were referred to health care professionals as required. We read in the care plans that there had been involvement from GPs and dietician and the manager said referrals were made to the relevant health professionals as and when required. Relatives said staff let them know if their family member was unwell or they though their needs had changed. One told us, "They are very good. I come every day, but they ring me as well if anything changes."

Requires Improvement

Is the service caring?

Our findings

The manager said people were offered rooms at Palm Court only when the pre admission assessment had shown that they could meet their needs, however their choices were restricted. They told us people who were contracted through the local authority were offered rooms in the older building, while those who were paying for services themselves were offered rooms in the extensions. It was not clear if people and their relatives were aware of the difference between rooms in the older and newer parts of the home. This meant people were treated differently based on their ability to pay, which was not caring and supporting people's best interests.

Staff told us people had their own preferences about where they wanted to sit; although we had not seen staff consistently ask people where they wanted to sit in the lounge, particularly at lunch time. Two people sat together in the lounge every day and clearly enjoyed sitting quietly, chatting and supporting each other with encouragement with meals and drinks. Staff said people were encouraged to be independent and as mobile as they could be with support from staff if required. Staff said they knew people well, "Some people prefer to remain in their room. We ask them every day and support them to go into the lounge if they want to, but they usually want to go back quite soon."

Staff said people were supported to make choices, such as the clothes they wore. "We show a few different colours and ask them what they want to wear." "Some like jogging bottoms or trousers and some of the ladies like to dress really well and have their hair done." Although other people don't like us brushing their hair and we have to wait a bit and then ask again later." Staff told us they assisted people to apply makeup if they wanted to use it and a number of people had their nails varnished, in colours of their choice. However, there were instances when people had not been supported to make choices. In one person's records it stated they did not like music, but staff had tuned their radio into loud techno music and this was on for the whole day. They were unable to switch the radio off or ask staff to do it for them. Staff had been unable to show a good understanding of people's individual needs and therefore had not supported them to make choices about the activities provided.

People spoke positively about the staff. "The girls are really lovely." "I'm doing fine. It's like home from home with them helping you a bit" and, "I am quite comfortable here." Relatives said people were looked after very well, "They always look clean and comfortable" and, staff were, "Very caring" and, "Seem to know what they are doing." Staff told us that although sometimes they were rushed, they knew people very well and provided the support and care people wanted.

Some people chose to walk around the home and spend time in the lounge and their own room and some staff supported people to use the correct walking aid when they moved around the home. We saw staff treated people with respect when they asked them if they needed assistance to use the bathroom or return to their rooms for a lie down in the afternoon and, when they used a hoist to assist people staff ensured they were covered to protect their dignity.

Relatives and friends said they were able to visit at any time and staff said they encouraged people to

maintain relationships with relatives and friends. Relatives told us, "I visit every day and assist with their afternoon snack and supper while I am here" and, "I am always made to feel very welcome, I have a cup of tea and sit chatting in the lounge." Staff talked to people and their relatives when they had time, the conversations were friendly and on first name terms.

Inadequate

Is the service responsive?

Our findings

At our inspection on the 30 December 2014 and 12 January 2015 we found the provider was not meeting the legal requirements in relation to the provision of appropriate activities based on people's preferences. The provider sent us an action plan stating improvements would be completed by 12 August 2015. At this inspection we found that these improvements had not been met, this was a continued breach, and we identified other areas where improvements were needed.

People told us, "I sit here and read a book, I don't do much" and, "There is not much to do and it is very quiet." Relatives said there were not enough activities. "People spend a lot of time sitting in the lounge." "I would like to see some more activities" and, "I don't think she is interested in activities anymore, we listen to the radio and sit chatting." Staff told us they did not always have the time to spend with people to do activities, "Or just talk to them." People spent their time in the lounge or their own rooms, there was very little interaction between staff and people on the first day of the inspection and although this improved for the second day this was the result of feedback during the inspection. Relatives were aware of the complaints procedure and said they thought the manager would address issues or concerns they had.

Activities were not provided on the first day of the inspection and on the second day we did not see any structure to the activities. Staff were sitting with people talking and singing, but there was no evidence that activities had been personalised to people's individual preferences and choices. One member of staff said, "I haven't seen any games or other activities like balls in the home, so what we can do seems to be very limited." Another told us, "We can use personal care as part of an activity, we talk to them about things they are interested in books, music or TV."

Staff said they checked on people who chose to remain in their rooms half hourly and spent time with them when they could. Records were kept of these checks and consisted of statements like, 'sleeping, awake, and listening to music'. However, we found that support was not consistently based on people's choices. For example, one person had an interest in motor bike racing and had specific food preferences. Their power of attorney had arranged for someone to visit regularly with a biking magazine and meals of their choice, but this was not provided at any other time. Staff were unable to explain why this support was not available to this person more frequently

On the first day of the inspection people in the lounge had very little stimulus and interaction with staff involved assistance with meals or personal care. The atmosphere in the lounge was quiet and calm, but this was because of the lack of activity rather than the provision of appropriate support and care. We saw people were sitting waiting for their next meal or for something to happen. Some people had a newspaper to read but most were bored and slept for long periods. One person sat in their chair from before 7.30am on the first day of the inspection until after their relative arrived in the afternoon. Staff did not talk to them unless they gave out meals and drinks and they were isolated and alone, even though they were in the lounge. Another person sat at a dining table on their own for over an hour, watching what was going on, but not involved and staff did not speak to them. We spoke with several people and they were happy to engage and chat to us, or they smiled as we sat with them talking about what we saw people and staff doing in the lounge. The lack of

activities and interaction showed that staff had not understood people's needs and choices, or were unable to provide support based on their preferences, which had a negative effect on people's health and wellbeing.

We provided feedback during the inspection and at the end of the first and second days, to inform the manager and staff of any concerns we had. We discussed the issues we identified. On the second day of the inspection the armchairs in the lounge had been re-arranged for people to sit in small groups of three to five and, there were more staff on duty so they had time to spend with people in addition to providing assistance with meals and personal care. Relatives told us this was much better, people were able to socialise with each other if they wished and it made the environment seem much friendlier and happier. Staff also said it had improved people's experience and we saw staff were part of each group and encouraged people to talk.

The manager said people's needs were assessed before people were offered a room at Palm Court. We looked at the care plans for the four people who had recently moved into the home and found assessments completed before they moved in contained information about people's medical and social history, their next of kin and reason's for moving into the home. However, some of the information was not clear, it had not identified people's specific needs and there was no clear guidance for staff to follow. In one care plan we found the records did not state when one person had moved into the home. There were two different dates in the care plan, three days apart, and staff were unable to tell us what time or day the person had moved in. There was no information about who had assisted the person to move in, if any observations had been taken, such as temperature and blood pressure; their mood and how they felt about moving from their previous home. There was no record of them being offered a drink or something to eat, or made comfortable in Palm Court. The previous home had provided some information about their individual needs and this had been copied into the care plan, but the guidance for staff had not enabled them to meet the person's needs. For example, the person's needs had changed, but there was no plan to support this and no clear guidance for staff to follow to keep the person, other people and staff safe. We asked staff how they supported this person. They said, "Stays in bed if they remain in their room because they are at risk of falls." "Is able to ask for help, but does not always want us to support them with personal care, so we go back later." "Sits out in the lounge when they want to, which is not every day" and, "They sit out in their chair in their room if they don't want to come into the lounge." This showed staff could not demonstrate an understanding of the person's needs. The care plan should clearly state how the person's behaviour might change; if there are any triggers that bring about the changes; can staff support them with distraction to reduce the risk and, clear guidance for staff to follow to reduce the risk of falls without restricting their choices. The lack of appropriate records, with guidance for staff to follow, meant care may not be personalised and people may be at risk of support and care that did not meet their needs.

Staff told us that, because of the staffing issues, they felt they had been unable to provide care that was personalised to meet people's individual needs. One member of staff said, "I don't always feel like I have had a good day. I like to feel that we have looked after people well and they have had a good day, but sometimes we are rushing around and only do the basics." The manager and staff told us the support provided was task orientated and not specific to meet each person's needs and, "We know that improvements are needed."

The provider had failed to ensure staff had appropriate guidance to follow, based on current guidelines, for the provision of personalised care and support for people that met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said the care planning system had changed since the last inspection, the computer based

system was no longer used and all records were hand written. They told us they had read all the care plans and had been reviewing and updating the information recorded so that it was, specific to each person, identified their needs and included appropriate guidance for staff to follow. One of the changes the manager had introduced was that all staff were required to record in the daily records the support and care they provided for people before they left the home. These records were then checked by the nurse in charge and they signed the records to evidence they had done this. Additional training had been arranged so that the information recorded included people's mood, the activities they participated in as well as support with personal care.

Relatives said their family member had been assessed before they moved into Palm Court. The provider or manager had visited them and discussed their health and social care needs, with the relatives support. Relatives told us they had visited the home to look at the rooms and meet staff and they thought this was a good idea.

Relatives said they knew about the complaints procedure and this had been included in the information they had been given before their family member moved in to the home. One relative said they had talked to the manager about a couple of issues, these had been dealt with and they were confident if they raised concerns they would be addressed. Another relative told us the manager and staff were available at any time if they wanted to discuss anything. "They always pop in and make sure everything is ok, I don't have any worries they are very good."

Staff said they would try and deal with any issues or complaints immediately, "If it's about food, maybe not hot enough or they want something else we can sort that out straight away." If they were unable to address the concerns then they would refer it to the senior staff, nurse or manager. The manager said there had been no complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

People told us the staff were very nice. One person said, "They've woken me up coming here, given me a new start." Relatives said the manager was very approachable and they felt they, "Know what they are doing." Staff told us things had improved since the current manager had started and they felt more supported and involved in decisions about the care and support provided. However, whilst there were plans in place to improve the services provided, people had not experienced consistently good care during the inspection.

Palm Court had not had a registered manager responsible for the day to day management of the home since January 2015. We have been told that three managers had been appointed, but none had applied to register with CQC as the registered manager. They had left within a few months of their appointment and feedback has been that they had not felt supported and had been unable to make decisions about the services provided. The provider put forward an application to register as the registered manager, but withdrew the application before a decision was made by CQC. The lack of a consistent registered manager leaves a service at risk and this is why it is a condition of their registration.

The main issue identified by people, relatives and staff was the lack of staff and the impact this had on the provision of activities and opportunities for people to socialise. The manager said they had been actively advertising for nurses and care staff, one care staff had been appointed to work on nights, two more would be starting shortly on days and a nurse had been offered a post, subject to the necessary checks. In addition, a member of staff from the provider's other home was moving to work in Palm Court as the activity organiser to provide a range of activities based on people's preferences. Whilst the manager said they were aware that more staff were needed and they expected to increase the staffing numbers. There was no evidence of forward planning, such as advertising for new staff as soon as staff have handed in their notice.

The current manager had been in post for nine weeks before the inspection and told us they would be applying to register with CQC as soon as possible. They had spent their time reviewing all aspects of the services provided and had involved people, staff and relatives in discussions about proposed changes. The manager had not noticed the poor moving handling until we discussed our observations with them and they then modelled good practice.

Palm Court Nursing Home has been promoted as a Centre of Excellence for people living with dementia and the Statement of Purpose informed relatives and people that, 'Regular teaching and supervision strategies are in place to enhance practice'. However, staff did not consistently demonstrate an understanding of people's needs and how these could be met. For example, staff had not been concerned about the positioning of chairs along the edge of the lounge and some thought it was appropriate. One member of staff told us, "The night staff usually move the chairs because they have to clean the floor and the cushions." We asked staff if they thought this was appropriate, one said "We need the space to use the hoist and transfer people. It means we don't have to move the chairs." Staff were making decisions based on their work rather than allowing people to be involved and make choices about the support they received. This was not identified by the provider or the manager.

The quality assurance and monitoring system was not effective. Improvements had not been made since the last comprehensive inspection with regard to staffing, training, activities and personalised care and, these were on going breaches of regulations. Monitoring of the services had not identified the areas we found where improvements were needed. For example, food and fluid charts were used to record the amount people ate and drank each day and staff said they ensured people had sufficient fluids and a nutritious diet to meet their individual needs. However, records stated people had eaten all or half of their meal. Staff had not recorded what people had actually eaten; they were not sure if people had had enough to eat and there was no additional support in place, such as finger foods for people who needed additional dietary support to ensure their weight was stable. Records did not demonstrate that people had nutritious meals with appropriate calorie intake over a 24 hour period.

The provider had not sent out satisfaction questionnaires, to obtain feedback from relatives and health and social care professionals. The manager said they planned to do this as soon as possible. However, as part of the quality assurance system feedback should be sought from people who use the service, their representatives and other stakeholders, so that areas for improvement are identified and action can be taken to address them. There was no evidence that opinions had been sought from any parties involved in the service.

The manager said they had reviewed some of the quality assurance system and some audits had been developed and introduced; such as those for the environment and where issues had been identified actions had been taken to address them. They told us they had been reviewing the care plans and had been looking at how changes could be made to ensure they were specific to each person to identify and meet their needs. However, only some changes had been made and considerable work was needed to ensure the care plans included clear information about people's needs, with appropriate risk assessments and guidance for staff. The manager agreed this would take some months to achieve.

Systems for the management of medicines were in place and a monthly audit had been used to assess if the systems were effective. However, we found there were gaps in the medicine administration record (MAR) and, although the audits had identified these no action had been taken to address this effectively or safely. Staff said if there was a gap they would inform the person responsible at that time and they would sign the MAR as soon as they could afterwards. This does not follow current guidance from the Nursing and Midwifery Council which states: 'you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine'. The failure to sign the MAR meant people were at risk of not receiving prescribed medicines or receiving more than the prescribed doses, which may affect their health and wellbeing.

Before the inspection, we asked 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. Which is a requirement of the inspection process. The provider submitted a PIR after the inspection.

The provider had failed to ensure an effective quality assurance and monitoring system was in place to identify areas for improvement and make changes and develop the service to meet people's needs and, had not sent a written report requested by CQC to the commission. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said they had been working with the local authority since the last inspection to improve quality assurance and record keeping and, meet the breaches in regulations identified at the last inspection.

The manager said some improvements had been made, but there was still some work to ensure they could show that all aspects of the support and care provided was appropriate. The feedback from the local authority was that they continued to work together.

The manager had an open door policy and the provider or manager were on call so that they were available if staff needed advice or support at any time. They told us that changes were needed to ensure that appropriate care and support was provided for people and had realised this may take some time to achieve. The manager said staff were, "Keen and motivated" to bring about the improvements needed and had a good understanding of how this could be achieved. "They work well, they communicate with each other and are a good team." Staff meetings had been introduced, one meeting had taken place and the manager planned to introduce regular residents/relatives meetings. However, it was not clear if this had had a positive effect on the support and care people received. Issues such as inappropriate moving and handling and lack of communication between staff and people were still evident and, the only changes we observed were the result of feedback on the first day of the inspection.

Staff felt they worked well together as a team and enjoyed the teamwork approach to providing care. They said the manager was very supportive and encouraged them to put forward suggestions and make comments about the care and support they provided and what can affect this.