Akari Care Limited

St Marks Court

Inspection report

73 Split Crow Road
Deckham
Gateshead
Tyne & Wear
NE8 3SA
Tel: 0191 490 1192
Website: stmarkscourt@akaricare.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 6 and 10 November 2014 and was unannounced. This meant the staff and the provider did not know we would be visiting. We last inspected St Marks Court on 17 and 21 July 2014.

At the last inspection we found the provider was not meeting all the regulations we inspected. We found people's care and treatment was not always planned in a way that ensured their safety and welfare; the service had not always taken steps to provide care in an environment that was adequately maintained; there were not enough qualified, skilled and experienced staff to meet people's needs; staff did not always receive appropriate training and suitable appraisal and supervision arrangements were not fully in place; the systems the provider had in place to monitor the quality of service people received, were not effective, or undertaken on a regular basis. An action plan was received from the provider which stated they would meet

Summary of findings

the legal requirements by 30 September 2014. At this inspection we found improvements had not been made in relation to three of the five breaches and there were two further breaches of legal requirements.

St Marks Court is a care home which provides nursing and residential care for up to 60 people. Care is primarily provided for older people, some of whom are living with dementia. At the time of our inspection there were 45 people living at the home. Accommodation at the home is arranged over three floors. The ground and first floor being dedicated to providing accommodation and care for people requiring general nursing needs and residential care. The second floor is for people living with dementia.

The home did not have a registered manager, as the manager in post was awaiting the outcome of her application for her CQC registration. Following our inspection, the manager received her CQC registration. 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 majority of people at the home, their friends and relatives told us there were not enough staff on duty at important times. Seven of the ten care staff we spoke to told us they felt they were insufficient staff on duty at all times. They said this had an effect on the time they were able to spend with people and had a negative impact on the care and support that they were able to provide. The recording of people's medicines was not managed safely. Plans to describe how people should be evacuated out of the building in the event of an emergency were not available for each person who lived at the home. Although members of staff told us they completed safeguarding adults training, two care assistants were unable to describe what constituted abuse.

Since our last inspection where breaches of regulation had been identified, we found staff had been receiving regular supervision. However, we found some of the supervision sessions had been undertaken by line managers who had not received training on how to carry out effective supervision sessions. We also noted that no members of staff had received an annual appraisal since our last visit.

There had been an increase in the number of staff who required, or were overdue refresher training, from the previous inspection in July 2014. Six members of staff, including registered nurses and the home manager were overdue their annual medicines training and medicines competency assessments. We also saw that medicines competency assessment certificates were not available for staff who had completed their annual medicines assessment update.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Safeguards (DoLS), and to report on what we find. These laws protect people who may lack capacity and their ability to make/be involved a particular decision at the time it needs to be made. It also ensures that unlawful restrictions are not placed on people in care homes and hospitals. Important decisions are made in the best interests of the people. We found a lack of knowledge and understanding around appropriate assessments and applications to supervising bodies for authorisations.

We were told by three health professionals who visited the home that people were not always supported to eat and drink to maintain their health, as advice and instructions given to staff were not always followed. We observed there appeared to be a lack of knowledge and confidence amongst the staff about dementia care and the ability of staff to support people with mental illnesses.

People's care records did not always accurately reflect their needs, or contain sufficient detail or information for staff to provide adequate support. Risk assessments for people who were nursed in bed and had swallowing difficulties and were at risk of choking were not consistently applied.

Current systems to regularly assess and monitor the quality of services or identify, assess and manage risks relating to people's health, welfare and safety were ineffective. Previously identified breaches of regulations had not led to the necessary improvements required and additional breaches of regulations were also identified during the course of this inspection.

The majority of people and their relatives told us staff treated people with kindness. We saw caring interactions between people and staff and there was a friendly

Summary of findings

atmosphere around the home. People told us they enjoyed the meals at the home. Recruitment practices at the service were thorough, appropriate and safe. Three members of staff were singled out by a health professional for the care and support they provided and we saw that referrals had been made to the challenging behaviour team in relation to two people. This had resulted in a reduction in the level of distressed behaviour for one person. The majority of staff told us staff morale had improved following the arrival of the new manager at the home. All of the staff we spoke with felt the manager was supportive and approachable.

We have recommended that the service explores the relevant guidance in dementia care and supporting people living with dementia in meaningful activities.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. We found staff were recruited appropriately and safely, however there was not always enough staff to meet people's basic needs.

Staff knew how to report abuse but could not always explain what abuse was.

We found that medication was administered and stored safely, but record keeping around medication administration was not managed safely.

Is the service effective?

Inadequate

The service was not effective. We found there were gaps in the provision of training for all staff which meant people were at risk of unsafe working practice from staff who did not have the skills and knowledge to consistently meet their need. This was evident as staff lacked the knowledge and confidence about basic care of people with dementia and progressive mental illness.

We found that there was limited understanding of Mental Capacity Act (2005) and DoLS which meant the code of practice was not applied consistently or appropriately so people were at risk of their human rights to make particular decisions was being denied to them.

People told us they enjoyed the food prepared at the home, but we found people were not always supported to eat and drink to maintain their health as advice and instructions received from health professionals were not always followed.

Is the service caring?

Requires Improvement

The service was not always caring. There was mixed feedback from people. Some said the staff were "lovely", others that, "Some are good, some not so good," and that they just wanted the job over. Staff told us they were too busy to spend quality time with people: we also saw this to be the case.

Some staff treated people kindly and with respect but people's privacy was not always respected, as confidential information was clearly visible and accessible in nurses stations with doors open.

Is the service responsive?

Requires Improvement

The service was not always responsive. We found that a lot of people were nursed in bed and care plans did not always explain why or how to nurse people appropriately. Care plans were written in the first person and carers we spoke with had a good knowledge of people, but this wasn't always reflected in care plans.

Summary of findings

An activities coordinator was employed and we saw that a variety of activities were on offer, but they didn't always meet people's needs or preferences. We observed that most people were in their rooms with little stimulation, which presented a risk of social isolation.

Is the service well-led?

Inadequate

The service was not well led. The service did not have effective systems in place to ensure it was well-led.

Current quality monitoring systems being used did not always ensure the service was operating safely and effectively.

Some of the actions we asked the provider to take at our last inspection remained outstanding and had not addressed previous breaches of regulations.

St Marks Court

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.

The inspection was carried out by two inspectors, an inspection manager, a specialist advisor and an expert by experience both with expertise in older people and dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the home, including the notifications we had received from the service about serious injuries and deprivation of liberty applications. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also reviewed whistleblowing reports and complaints that had been received. We contacted the local authority commissioners for the service and did not receive any information of concern. Following the inspection, we contacted a senior community dietitian, a speech and language therapist clinical lead, a local authority Mental Capacity Act 2005/Deprivation of Liberty Safeguards lead and an older person specialist nurse.

During the inspection 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.

We spoke with 16 people who used the service and 10 of their friends and relatives. We also spoke with the manager of the home, the deputy manager, the provider's regional manager and 12 members of staff. We looked at a range of care records, which included the care records for eight of the 45 people who used the service, eight medication records, recruitment records for six staff members, duty rotas, the staff training matrix, training records and selected policies and procedures.

Inadequate

Is the service safe?

Our findings

During our last inspection in July 2014, we were concerned about the staffing levels at the home. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan outlining how they would make improvements.

At this inspection, we found there were not enough qualified, skilled and experienced staff to meet the needs of the people living at the home. The action plan we received from the provider stated that staff rotas would be planned in advance. They gave assurances they would meet the legal requirements by 30 September 2014. Staffing rotas we viewed showed gaps in staffing for the week of the inspection. We saw that nursing shifts had to be covered by the manager and agency nurses.

We received mixed opinions from people and their friends and relatives about staffing levels. One person told us he felt safe and that all his needs were met. However, another person's comments included, "Sometimes the staff are busy and you have to wait a bit for help, especially my morning hoist… it's not their fault, but the staff seem stretched a lot of the time," and, "I'm happy with the care I receive, but I think they could do with extra staff to help out." Other people commented on how busy the staff were. Their comments included, "We really need more (staff)" and another person waiting for support with personal care said, "I always wait longer than this; they are more bothered about the chickens than us today."

We observed a number of occasions where people had to wait for assistance when they had activated their call bell for personal support. We saw that the refreshment round which was due at 11.00am, was not completed until 12.20pm on the nursing floor. Staff members told us this was due to the unavailability of staff. One relative told us that one person waited 30 minutes for assistance as a staff member was on a break. Another visitor told us their friend required hoisting and had to wait 20 minutes, as this was a procedure which required two members of staff and the second member of staff was on a break.

We spoke with two domestic staff and 10 care staff about staffing levels at the home. Both domestic staff told us that there had been improvements in their staffing rotas, shifts and working conditions since our last inspection. Three care staff told us told us they felt there were enough staff to keep people safe and meet their essential needs. However, they felt that they were only able to provide basic care and were unable to spend any quality time with people. One care assistant told us, "Basically, there is enough staff to look after people. But we don't have time for anything other than their basic care needs though. The buzzers can ring a long time when things are busy. They could do with more staff on to look after people – especially in the mornings." Another care assistant's comments included, "When the floor's full and there's more residents, you never get the time to really meet people's needs. It's not so bad at the moment, as we are not fully occupied. Yes we get morning, lunch and tea-time breaks the majority of the time. If we are short staffed we miss out," and, "I don't feel I have enough time to spend with people. Sometimes you do in the afternoons, but not on a morning; you just flit from room to room."

Seven care staff told us they believed there were insufficient staff at all times and that this was detrimental to and having an impact on the care they were able to provide to people. One senior care assistant told us, "There are not enough staff on to look after people properly, definitely not. You could do with extra staff on duty. You need an extra carer on the ground floor and on the first floor. Residents' refreshments should be given at 11.00am – they are not getting them until 12.30pm and that's too near to lunch time. People's care is being affected by the lack of staff. We're not happy with that, as people are having to wait for things and get assistance." A care assistant told us, "People aren't getting the care they need promptly; even their drinks are delayed. If people want something, they are having to wait due to the lack of staff available." Other care assistant's comments included, "Everything is hectic; you don't have the time to talk to people, other than when you are feeding them, or giving them personal care… I enjoy working here, but it's hard going, rushed and you're tired," and "During your shift, there's not really enough time to spend with people. You're lucky if you get the chance to say hello to some of the residents, we are that busy. We can't sit and talk, we haven't got the time."

To help plan the numbers of staff needed, the manager told us they used a dependency tool to determine the staffing levels needed at the home. We saw the dependency tool did not indicate nursing requirements or other factors such as the layout of the building and busy times throughout the day. This meant that the staff rotas and dependency tool

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did not show how staff should be deployed throughout the home, to meet the differing needs of people across the three floors. They were also not flexible to reflect people moving between floors for day support.

The manager told us following our last inspection, two nurses were on duty during the day, but this had recently reduced to one nurse as they now had most of the people who required nursing support on one floor. One nurse told us, "If I'm honest, we need two nurses." Another nurse told us, "As a nurse it's worrying," when explaining that four people on the ground floor had nursing needs and required daily medication, yet she was based on the nursing floor on the first floor.

We saw the deputy manager worked nursing shifts and the manager told us she was not allocated any supernumerary time for other duties. The deputy manager's comments included, "When I first came here in September there were two nurses on dayshift. Now there's only one dayshift nurse; it's hectic and hard work. I would love another nurse, at least a nurse between 9.00am and 2.00pm. They (care staff) are meeting people's needs, but it's difficult, as there are a lot of bed bound people," and "We don't get to spend any quality time with people; it's better in an afternoon, but not in the mornings… I don't get breaks, I'm just too busy."

Following our inspection, we contacted three health and social care professionals from the local health authority, for their opinion of the service. The older person specialist nurse told us that she had recently had concerns regarding the staffing levels at the home and had reported this to the local authority contracts and commissioning team.

This meant there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The actions we have asked the provider to take can be found at the back of this report.

We viewed safeguarding and whistle blowing policies at the service. The majority of staff we spoke with had a good understanding of what constituted abuse and what action to take if abuse was suspected. Two members of staff we spoke with were unable to give an example of a form of abuse. Staff we spoke with told us they had received safeguarding adults training, however training records we reviewed showed that 16 members of staff were overdue safeguarding adults training. The lack of up-to-date training meant that some staff were not fully aware of current practice and guidance which put people at risk.

Staff knew about whistleblowing and who to contact if they felt their concerns were not dealt with properly. Whistleblowing information and contact details were on display in the home. The manager told us, and records confirmed, that investigations into whistleblowing reports, staff concerns, safeguarding, accident and incidents at the home were collated weekly and were subject of a monthly review by the regional manager, to identify trends and prevent reoccurrences.

We noted that personal emergency evacuation plans (PEEPs) to describe how people should be evacuated out of the building in the event of an emergency were documented and in place. However, we noted that there was not a PEEP in place for each person. We also saw contingency plans were in place in case of a fire, flood, loss of utilities, or other emergency. The registered manager told us, and records confirmed that the provider operated an out of hours contact facility where staff were able to contact a duty manager for advice and in the case of emergencies.

We examined six records for staff who had recently been employed at the home. We found that the home operated appropriate and safe recruitment practices. We saw each file had a completed application form, detailing their employment history, reasons why their employment had ended and proof of their identity. We also noted that security checks had been made with the Criminal Records Bureau (CRB), or the Disclosure and Barring Service (DBS), as it is now known. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Police records and, in relevant cases, barred list information, are checked and a DBS certificate is issued to the applicant. At least two written references had been obtained and verified, where possible, from a previous employer.

People's medication was stored safely and records were kept for medicines received and disposed of. We saw there were suitable procedures for the safe storage and administration of controlled drugs. Controlled drugs are medicines which can be misused and therefore stricter legal controls apply to these medicines to prevent them being obtained illegally, or causing harm.

Daily room and refrigerator temperatures were recorded where medicines were stored. This meant suitable arrangements were in place to ensure the safe-storage of both refrigerated and non-refrigerated medication. We

Inadequate

Is the service safe?

viewed eight people's medication administration records (MARs) and the MARs contained a photograph of the person to prevent errors and ensure medicines were not being given to the wrong person. We found people's medication was administered appropriately and contained people's preferences as to how their medication was administered. However, we saw that staff initials on MARs did not always correspond with the signature sheet for administration. We saw some signatures on MARs looked similar to the coding system used if medicines were refused, or omitted. We also noted that some signatures were not completed on the MARs, although the stock count did reflect the correct administration of medicines. Where staff signatures were entered, we saw some entries overlapped into other records and it was not always clear which signature referred to which entry.

This meant there was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The actions we have asked the provider to take can be found at the back of this report.

At our inspection in July 2014, we asked the provider to take action to make improvements to the communal toilets, showers, bathrooms, the laundry and all three communal kitchens / dining rooms, as we saw they were not adequately maintained at the home. This meant there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements.

At this inspection, we found that all the issues identified at our last inspection had been addressed and necessary refurbishments made. People and their relatives told us they were happy with the condition and cleanliness of the home. One person's told us, "It's a very clean home… this is the eighth home I've been in, it's the only one where it's been cleaned to my standards." We found the home was clean and no unpleasant odours were evident in any part of the home.

Inadequate

Is the service effective?

Our findings

During our last inspection in July 2014, we asked the provider to take action and make improvements. We were concerned that staff did not always receive appropriate training and suitable appraisal and supervision arrangements were not fully in place. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.We asked the provider to send us an action plan outlining how they would make improvements.

The action plan received from the provider stated that all staff would be supported through a robust supervision process and line managers would receive training on how to carry out effective supervision sessions. In addition, all staff would receive the minimum six supervision sessions a year, receive an annual appraisal and be adequately supported to deliver the required standards of care to people. The action plan received from the provider gave assurances they would meet the legal requirements by 20 September 2014.

During this inspection, we viewed the supervision records for all staff employed at the home. We saw staff who should receive a supervision session, had received at least one supervision during August to September 2014, following the arrival of the new manager at the home on 4 August 2014. Records examined, confirmed 10 members of staff had received a second supervision session during October and November. The manager told us the remaining members of staff would receive their second supervision session by the end of November 2014. Supervision sessions are used amongst other methods, to check staff progress and provide guidance. Lack of supervision sessions and appraisal could mean the competency of some staff might not be assessed and support may not be provided if gaps in their knowledge, or skills were identified. We saw that 19 of the supervision sessions conducted during August and September 2014, had been undertaken by line managers and supervisors who had not received training on how to carry out effective supervision sessions. We spoke with the manager who accepted our findings, acknowledged that line managers and supervisors had not received the support and training as stated in the action plan and that she hoped to arrange this training during January 2015.

In addition to supervision sessions, the manager told us that all staff should receive an annual performance review, known as an appraisal. Appraisals provide a formal way for staff and their line manager to talk about performance issues, raise concerns, or ask for additional training. At our last inspection, we were concerned that staff were not receiving an appraisal. At this inspection we found appraisals were not being conducted and no appraisals had been carried out since our last visit. The manager told us she us she was going to commence appraisals in January 2015 and would conduct them on each staff member's anniversary of joining the service.

During our inspection in July 2014 we were concerned about gaps in the provision of safe working practice training. The manager and the regional manager told us they had identified issues with training courses that needed to be refreshed and had recently arranged for some refresher training to be undertaken. We were told during the inspection in July 2014 that all overdue refresher training would be arranged at the earliest opportunity.

During our visit, the manager told us that 51 staff were permanently employed at the home. The manager also told us and the provider's training policy confirmed, that all employees were required to undertake annual training in a number of areas, which included fire drills, fire safety, first aid, food hygiene, health and safety, infection control, Mental Capacity Act 2005, moving and handling and safeguarding adults.

We examined staff training records and saw gaps in the provision of safe working practice training. We saw 22 staff required dementia awareness training; nine staff required training in fire drills; 15 staff required fire safety training; seven staff required first aid training; 11 staff required food hygiene training; 12 staff required health and safety training; 15 staff required infection control training; nine staff required moving and handling training and 16 staff required safeguarding adults training. In addition, 21 staff required nutrition and hydration training and 16 required Mental Capacity Act 2005 training. These figures show an increase in the number of staff who required, or were overdue refresher training, from the previous inspection in July 2014.

We viewed figures for medicines training and competency assessments and found that four senior carers and one registered nurse had completed their annual medication

update. We saw six staff were overdue their annual medicines training and competency assessments. This included two registered nurses, the home manager and two senior carers.

The manager told us all senior care staff and nurses were required to complete medication competencies and said, "All mandatory training is refreshed yearly."

We noted that training was a standing agenda item in supervisions, but training records in staff files were dated August 2014, so any training in the months August to November had not been recorded in staff files. The manager confirmed, "These would be updated for the next supervision." It was also noted that medicines competency assessment certificates were not available in staff files.

All staff members we spoke with told us they had regular safeguarding adults training. One domestic member of staff told us, "Yes, I've had the training (safeguarding). I think it's due again, but I don't know when. I couldn't tell you when I last had it. Most of my training is up to date" and, "As far as I know, my training is up to date. There's some due to be refreshed, most of them really. I had fire training a couple of months ago. We just get told when they are due." One nurse told us, "All my training is up to date, but I would like to do more in-depth training. Some of the training needs to be more comprehensive."

There was contradictory information about training, but the reports on training compliance and staff member's lack of knowledge meant that people were at risk of receiving care from staff, including nurses and the home manager, who did not have the necessary skills and training to meet their needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we told the provider to take at the back of the report.

Staff told us, and minutes of meetings confirmed, that staff meetings were now being held regularly. These meetings are used to keep staff informed of best practice and to discuss important issues.

We spoke with three recently appointed staff who told us they felt their induction, initial training and support enabled them to care and support people effectively when they started work. The manager told us all new staff were required to complete a six month probationary period and their suitability was reviewed after three months and on completion. The manager also told us that all new staff were required to complete the provider's 'Induction Workbook for Care Workers' to demonstrate their ability to meet the requirements of the Common Induction Standards for people working in adult care. However, no completed induction workbooks were available at the time of the inspection.

The manager and staff we spoke with told us they were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, we found it was not fully understood or applied consistently. The manager told us, "We do mental capacity assessments on all residents when they come in." She told us that an analysis of DoLS application requirements had not been undertaken and she was, "Just applying one at a time." DoLS applications are a legal requirement and are required to be made to the relevant local authority supervising body for authorisation. These applications are made in order to prevent unlawful restrictions being placed on people. For example, preventing a person with limited capacity and who may be at risk from harm from leaving the building unsupervised. These decisions are made in the best interests of the people.

We noted that mental capacity assessments had not been completed consistently. For example, one assessment recorded that the person had no capacity in relation to understanding information, retaining the information, or communicating the decision. However, the overall assessment was that the person had capacity. A further example recorded that the person had capacity with regard to the understanding of information, retaining the information and communicating their decision. The assessment then stated they did not have capacity with no explanation as to how or why this decision had been reached. This meant the service was not following the MCA 2005 code of practice. We also saw a MCA 2005 assessment which conflicted with a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) and the GP's judgement of capacity. This meant the human rights of people who may lack capacity to make particular decisions were not being protected.

Following our visit, we spoke with a local authority Mental Capacity Act 2005/Deprivation of Liberty Safeguards lead. They told us they had concerns regarding the lack of awareness and understanding of the MCA 2005 and DoLS

Is the service effective?

with senior staff at the home and commented, "Their understanding was questionable." They told us they had specifically spoken to the home manager as the wording on applications was a concern and it was almost as though they had, "Forgotten about the 'acid test' of capacity [deciding whether an incapacitated adult is being deprived of their liberty, which comprises two key questions - is the person subject to continuous supervision and control and is the person free to leave]." She also commented, "The way the form had been written showed what they didn't know about people."

Our specialist advisor noted that personal information was fully completed in most care plans. However, she could not find any documentation referring to identifying if anyone held lasting power of attorney for health or finance for people who did not have capacity to manage these. Identifying the person who has lasting power of attorney is important when people do not have capacity. Services should not assume this is the next of kin. If someone does not have capacity to make a decision then an Independent Mental Capacity Advocate (IMCA) should be consulted. An IMCA are independent people who represent and supports the person in relation to key decisions. This is particularly important if, for example, there are no family members to support a person with big decisions. We saw no evidence that IMCAs had been consulted.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we told the provider to take at the back of the report.

We noted that the challenging behaviour team were involved in the support of two people and their recommendation of a change in medication had reduced the level of distressed behaviour for one person.

People told us the food was "Good" and "You get a choice of two things." Staff confirmed alternate meals were available for people if they had special dietary requirements, such as vegetarian or diabetic. Staff went on to explain that some people do stay in their rooms for lunch but we observed that on the ground floor people were encouraged to sit in their comfortable chair for a meal rather than eat in bed. Whilst tables were generally well laid out we noted that menus were not on display. We saw evidence of a nutrition support plan and feeding regime that had been written by a dietitian. However, a senior community dietitian shared concerns that a letter sent to the home with specific instructions advising an increase of supplements from 2 to 3 a day was incorrectly filed and the instructions were not being followed.

The community dietitian team leader we spoke with told us her team had recently encountered problems when visiting the home. She told us weight charts, people's likes and dislikes of supplements, fluid balance charts, food record charts, food fortification charts were incorrectly filed, not up to date and staff had not been following previous advice and instructions issued by the dietetics team.

A health care assistant visiting on the day of our inspection told us they had no concerns about the care and treatment provided. We saw people had access to health care services, for example a tissue viability referral had been made for one person who had skin damage. The older person specialist nurse we spoke with told us they visited the home one day a week with the GP allocated to the service. They experienced difficulties accessing the nurse on a morning to enquire and find out about people's welfare and needs. They told us, "The nurses are continuously doing the medications round. The manager could assist but doesn't, or offer to assist with the medication round. The nurses are stressed and are always behind with the meds." The older person specialist nurse also told us the care staff at the home were good and a senior carer, an activities coordinator and the deputy manager were singled out for particular praise.

Requires Improvement

Is the service caring?

Our findings

At our inspection in July 2014, we asked the provider to take action and make improvements. We were concerned that care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. This meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements.

The action plan received from the provider stated that all care plans at the home would be subject to a full audit and review, to ensure people's needs were being met. The action received from the provider gave assurances they would meet the legal requirements by 30 September 2014.

People who used the service and their relatives gave us varied feedback about the care provided, although the majority of comments were positive. One person told us, "They are lovely staff and I could not imagine any better place to be. The care is wonderful." A relative commented, "How impressed I have been with the trouble that has been taken to make my mother's last years comfortable." However one person told us, "The staff are generally good, but there's a mixture. Some are good, some are not so good; they just want to get the job over as soon as possible and then go home."

During this inspection we used the Short Observational Framework for Inspection (SOFI). We saw positive and caring interactions between people and staff. We noted throughout our SOFI observation people were being supported to eat, drink and to express their preferences. For example, staff were observed offering alternatives to the choice of different courses at lunchtime. We observed one person laughing and enjoying a conversation with the provider's handyman.

Staff treated people with dignity and respect. We saw staff knocked on people's doors before entering their rooms and staff ensured any personal care was discussed discretely with people and carried out in private. One domestic member of staff told us, "We get training to ensure people's privacy and dignity; like knocking on the door and waiting for a response and asking to come into their room to ensure their privacy."

People's privacy was not always respected in relation to their confidential information. We saw the doors to the nursing stations on each floor were left ajar and personal care records were left on desks and confidential information was recorded on clearly visible whiteboards. For example, whether a person wished to be resuscitated in the event of a cardiac or respiratory arrest.

We saw one person sitting in a chair by the door of their room, shouting persistently and obviously distressed. This person had removed their shirt and pulled up their vest, leaving their abdomen exposed. They had a tray in front of them with a plastic spouted cup of luke warm tea in it. They engaged non-verbally and verbally with us and when reminded about their tea they had a drink.

When we spoke with staff about this person, although they seemed caring in their approach, they appeared to lack knowledge about how to support him. The support staff stated they had just dressed them and that they had stripped himself shortly afterwards. They said that they did not feel comfortable working with people whose behaviour challenged services. Staff were not seen going near the person for the rest of the morning. They were given lunch in their room after the other residents. They spent most of the day alone.

Whilst there has been an attempt to understand this person's preferences despite their lack of capacity and ability to express these, this has meant that this person was spending long periods alone. However they were clearly distressed during a significant part of this time. There is no care plan to systematically address this behaviour and evaluate what helps and what does not help.

The manager told us, and records confirmed that meetings for people using the home and relatives were held every two months. We saw topics discussed in the July and September 2014 meetings included the staff sickness levels and the removal of a cold water dispenser from the home. The manager told us she was to introduce monthly residents' and relatives' meetings commencing in November 2014.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. One relative said, "I'm always kept informed."

We saw information and contact details on advocacy services for older people and people living with dementia was on display on a notice board in the reception area of

Requires Improvement

Is the service caring?

the home. Advocacy ensures that people, especially vulnerable people, have their views and wishes considered when decisions are being made about their lives and have their voice heard on issues that are important to them. We noted that this information was not included the in provider's service user's guide or their statement of purpose. This meant advocacy information was not always easily accessible to people and their relatives. We discussed this with the manager and regional manager during our visit, who told us this would be included in both documents in the near future.

Requires Improvement

Is the service responsive?

Our findings

Some people living at the home told us about their experiences. Comments included, "Well and truly satisfied," "Everything's just right", "Good staff", and, "I get what I want."

We saw the majority of people spent all day in their rooms. We asked if this was normal practice, or if we had visited at an unusual time. Staff told us that this was normal. They had periods where more of the residents had wanted to get up, but at present most of the residents preferred to spend their time in their room. We also saw one person's care plan stated they liked to remain in bed, but no information was available to indicate why this person preferred to remain in bed, or how staff would meet this person's health care needs. For example, measures to reduce the risk of developing skin damage.

We saw that a lot of people were nursed in bed. One person told us, "I prefer to stay in my room, its better in here." We spoke with one person in their room. This person commented that they got fed up and said there is nothing they could do and, "I can just lie here and fry." They said they did not like watching television, but liked reading magazines. The person also told us they were waiting for an operation on their eyes. They told us they had not received any additional support, for example, a magnifying glass, or audio books.

This person was wearing hearing aids, but was unable to hear us without them speaking low and into our ear. On examination of this person's care records, it was established that this person had previously complained about staff not responding to her buzzer quickly enough.

They had a care plan entitled "socialising". This identified they were at risk of social isolation and would need encouraging to mix. There were only three records of them attending an activity. It was noted that they had poor eyesight but there was no evidence they had been assessed for how this would affect their ability to function, nor any evidence in the care plan they had been offered any suggestions, such as magnifiers and brighter light to help her read or alternatives such as audio books (which could be amplified), radio etc. It was noted they had hearing problems, but not when they had been reviewed by an audiologist.

Care plans did not consistently explain why people were nursed in bed or how to nurse people in bed. Care plans were in place and had been evaluated but people's views and involvement was not reflected. There was no evidence to show how people and their relatives were involved in reviewing care.

Care plans were written in the first person. We saw one example of a personalised care plan. This documented work done with external professionals and detailed the signs and symptoms of the person's behaviour that challenged the service. We however noted the detail and personalisation of care plans was not consistently applied to everyone who lived at the home.

Care plans did not routinely contain information about a person's likes or dislikes, or personal history. Care workers we spoke with had a good knowledge of people, but this wasn't reflected in the records.

We observed people involved with the arrival of chickens from 'Hen Power.' The manager showed us a newly constructed hen house at the rear patio area of the home. This had been provided by a registered charity and was a project to encourage older people to get involved in hen keeping as a way of reducing isolation and increasing health and wellbeing. One person told us, "I like the chickens; I like the rabbits and guinea pigs too. We have guinea pigs here, we get to stroke them and hug them."

The provider employed an activities coordinator and we saw that there were a variety of activities on offer, but not always on display. People were able to enjoy a range of one to one and group activities which included games, reading, gentle exercise, baking, pie and pea suppers, theatre trips and visits to the home from local school children and entertainers. Some people were observed engaging in baking and planning what next week's group would make. One person told us "activities for men are limited" and we observed most people were in their rooms, which presented a risk of social isolation.

We saw that the results of the 2013 annual survey were on display, but the manager told us that the 2014 summer survey was overdue and was unavailable. This meant people had not been given the opportunity to formally give their feedback on all aspects of the provider and home since 2013.

There was a concerns and complaints policy in place which detailed timeframes for action. Four complaints had been

Requires Improvement

Is the service responsive?

received since the last inspection and letters of response were available but there was no clear audit trail of the investigation. A relative had raised concerns which were recorded in the person's daily records, but this had not been recorded on the complaints log and had not been investigated. This meant we could not be sure the complaints procedure was consistently followed.

We reviewed the care records for five people living on the nursing floor. We found the documentation did not adhere to the Nursing and Midwifery Council guidance on record keeping. All registered nurses are expected to follow this guidance. Many entries in handwriting were difficult to read and signatures were difficult to decipher. Many of the entries were not timed. It was therefore unclear what had been written and by whom.

There was a Care Record quality standard displayed on the office wall which gave nurses direction in the minimum standards expected of them. This had been written by the manager and was an example of good practice.

All five care records had information stored in different places within the record. This made it difficult to find information quickly. 'Handover sheets' were used regularly, which listed all the residents and had information on care needs recorded for each person. We were informed these were mainly used for agency staff. These sheets contained information about both people's longer term and short term needs. We saw the handover sheets were regularly photocopied for use on a second day and therefore some of the information was not up to date and staff had changed this on some sheets and not others. Whilst handover sheets can be useful tools, they should be used as well as a verbal handover, for example, when handing care over to a member of agency staff.

Most of the care plans had an evaluation date next to them and we noted most of these were up to date. The evaluations did not detail where the evidence for the evaluation had been taken from (for example, recording sheets for positional change, food and fluid charts, continence charts etc.) There was no evidence the support workers had been asked to input into this process and the care assistants we spoke with, could not recall having been asked to take part in care plan evaluation. There were some instances where information was being recorded on daily record sheets, but there was no evidence the nurse was aware of this, as there were no actions in the care plan. We also found risk assessments for swallowing and choking were not consistently applied to all the people who were nursed in bed.

We saw a number of people who were living at the home were permanently nursed in bed. There was not always rationale for this in their care plans. Whilst people may be more comfortable at times in bed, there are also risks associated with permanent bed rest, including pressure damage, secretions and swallowing posture. One person's care plan we reviewed, we noted the assessment stated that this person had "no communication". It also stated that the person enjoyed people talking near them; getting their hair done and watching TV. These comments would suggest that they do have communication and we observed them turning her head to see people, making sounds and pointing. This service user had a suite of care plans which were all evaluated.

Care plans we viewed contained limited information about strategies to meet people's sensory stimulation needs. Examples of strategies could include therapeutic use of touch, such as hand massage, stroking, feet massage, music and sounds.

We recommend that the service explores the relevant guidance in supporting people with dementia in meaningful activities.

Inadequate

Is the service well-led?

Our findings

During our last inspection in July 2014, we asked the provider to take action and make improvements. We were concerned that the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. This meant there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements.

The action plan received from the provider stated that the manager would be supported with quality assurance audits and how to follow the company complaints procedure. It also stated the manager would undertake audits regularly and ensure records are kept to ensure these were completed in a timely manner. In addition, it documented that the regional manager would monitor the completion of all quality assurance audits, complete an IMPACT audit to identify poor practice, to assess and identify where improvements to current service provision could be made and address any areas of deficit and monitor complaints procedure and reporting. The action plan received from the provider gave assurances they would meet the legal requirements by 30 September 2014.

During this inspection we found that the systems in place to regularly assess and monitor the quality of services provided were ineffective, and not undertaken on a regular basis. Although systems were in place they did not effectively assess and monitor quality, nor did they identify, assess and manage risks relating to the health, welfare and safety of users.

We noted an IMPACT audit (specific audit type created by the provider) had been completed on 1 August 2014, which identified a number of areas that needed to be improved. Some of these improvements had not been actioned and there was no current action plan in place to evidence any progress made. The audit documented that life stories were missing from people's plans. However, an entry in the home development plan stated that this task had been completed on 25 August 2014. None of the eight care plans viewed during the inspection contained people's life stories.

We saw care plan file audits were undertaken monthly, however they were incomplete. The person conducting the audit was not always recorded to identify who was responsible for the audit. Where actions had been identified, we noted they were not always transferred to the action plans and implemented. There was no record that the regional manager had monitored the completion of these audits.

We saw where audits had taken place they were not always completed accurately. For example, we noted the medication audit had a question indicating whether all staff administering medication had received training and were assessed as competent. We noted this was marked as true, however during our inspection we noted gaps in medication training and competency assessments.

There was no evidence that Personal Emergency Evacuation Plans (PEEPs) had been audited and it was found that not every resident at the home had an evacuation plan. This had not been noted in any audit which left people at risk.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we told the provider to take at the back of the report.

We also found that the provider had not addressed the breaches of regulations relating to the planning of people's care and treatment; staffing levels; adequate staff training, supervision and appraisal and the effective monitoring of the quality of service people received found during our last inspection. In addition, we found additional breaches of regulations relating to people's consent to care and treatment and record keeping during this inspection. As we have identified new and continued breaches of regulations, we will make sure action is taken and report on this when it is complete.

Staff were asked their opinions by means of an annual employee satisfaction survey. We saw that dates for team meetings were advertised and on display throughout the home.

We saw staff meetings had taken place previously but were not regular. At the time of our inspection the last meeting for night staff was held on 16 September 2014. However, by

Inadequate

Is the service well-led?

looking at minutes of the meeting, we did note staff were able to raise concerns during the meeting, such as concerns in relation to night time care and standard procedures.

Staff we spoke with were unable to describe the values and culture of the organisation. We received mixed opinions about staff morale at the home. One domestic told us, "There are good days and some bad days. Morale has improved slightly with the new manager, but it could be better." A senior care assistant told us, "The morale at the home has been a lot better lately. Since [previous registered manager] left the morale with the staff has improved. She wasn't approachable….. [The current manager] made a positive difference." However, one senior care assistant commented, "There has been no difference in morale with the new manager coming in; it's still poor amongst the staff. I used to like working here, but we are just so busy, you go constantly home shattered."

The staff we spoke with, all told us they felt they were well supported by the new manager and were confident they could approach her at any time. They also told us they had seen some improvements in the home following the manager's arrival in August 2014. One senior care assistant told us, "I feel supported and the manger is very approachable. You can go in and she listens; more importantly what you tell her remains confidential." Care assistants comments included, "Yes, I feel the home is well-led; she seems lovely. It's a lot better; we have a manager we can talk to and she's regularly on the floor chatting to residents and staff," "I feel supported by the new manager; you can actually talk to her," and, "Yes, the new manager seems approachable. I feel I'd be comfortable if I needed to talk to her about anything."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.** Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.** Regulation 20 (1)(a), 2(a).

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1)(a).

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regulation 10 (1)(a)(b).

The enforcement action we took:
A warning notice was issued.