Cavendish Healthcare (UK) Ltd

St Marys

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 and 19 May 2016 and was unannounced. The previous inspection of 19 June 2015 found the service required improvement, with the domain of 'effective' being inadequate. There were breaches in regulation that related to staffing levels, support and training to staff especially in supporting people with dementia. People's needs relating to food was not suitably addressed. People's care needs were not adequately assessed, planned and delivered. Complaints were not well managed. There was a lack of oversight from management and a lack of action plans in place. We followed up all these matters at this inspection and found a degree of progress had been made, but not sufficient to show consistent safe care was effective for all. Given that our previous inspection, had also identified a breach of regulation with regard to the safe care and treatment of people and good governance we were not assured that the service had made the required improvements in the intervening period. For this reason issued two warning notices which required the service to ensure they met the legal requirements of Regulation 12 (1) and (2) Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 22 April 2916.

St Marys is a care home for older people. Some of whom are living with dementia. Up to 60 people can be accommodated. Constable is a part of the home that accommodates people living with dementia. At the time of our visit 23 people resided there. There were 44 people resident in total. Immediately after our inspection and feedback given the provider wrote to us to confirm that they would not admit any new person to the home. They agreed with CQC that they needed a time of consolidation and to improve the safety and quality of care afforded to people currently resident.

The newly appointed registered manager was unable to be present on day one and therefore we returned a second day specifically to meet and discuss matters that they had defined and were working on. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that staff were consistently kind to them. We observed some good interactions between people and staff. Staff demonstrated meaningful relationships with people. Activities were set to improve, but this was difficult to measure on the day as many things were planned, and yet to occur. Some people told us of a lack of stimulation and a desire from a small minority of staff for them to be fit in with the care being offered.

We had concerns about the healthcare and monitoring people at this service. We found examples of people who had not had swift intervention and ongoing monitoring when they had injured themselves. We found inconsistent monitoring and support for known medical conditions. Assessments relating to risks had not always been promptly reviewed and updated and therefore not all action was in place that could have been taken, to mitigate known risks to people. Care plans were in a period of transition from one set of paper work to another. The new model was an improvement on the previous files. However, we felt there was a

true risk during this transition period of information not being known and actioned. Medicine management was not as robust as it could have been. People were receiving medication prescribed, but we fed back two matters to improve upon in terms of records of administration and controlled medicines.

Staffing levels were now appropriate and recruitment was on going, but we found a manager who was not confident to delegate to the senior team due to their lack of training and knowledge and therefore single handled was unable to maintain and develop a service in need of raising its standards. The provider had known our concerns when they purchased this service in late 2015, but we were unable to establish at this inspection progress to 'good' safe quality care. The provider had not ensured that systems to monitor and audit the quality of care and safety had been systematically competed, actioned and followed up on. The provider was not fully aware of the day to day running and if people were experiencing the best care and support possible.

We found that complaints were appropriately handled, but a minority of relatives had leapfrogged over the manager in post and had not been encouraged to use the systems in place to resolve matters at a local level by the registered manager. People told us that they had confidence in the new registered manager. Staff were positive about the changes that were being brought about and keen to work with the manager whom they respected. Feedback from local health and social care professionals was that they had confidence in the new manager and believed that in time this service would improve. We are kept updated and appropriately informed of notifications and events by the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risk had not been identified and managed appropriately. Assessments had not been carried out in line with individual need to support and protect people.

People's medicine management was not robust.

There were sufficient numbers of experienced staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, and acted appropriately to protect people.

Is the service effective?

Requires Improvement

The service was not effective.

Staff received an induction but they were not adequately trained, competent and supported to meet the care and health needs of people in their care.

People had their health care needs inconsistently met and some people with specific conditions were placed at risk. People were not always appropriately supported to maintain diets that supported their good health. Specifically those people with diabetes, swallowing difficulties and those at risk of malnutrition.

Staff had received training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. The manager was aware and working to the act. Staff displayed a degree of understanding of the requirements of the act, but their competence and application was not tested to ensure people at the service had their rights maintained.

Is the service caring?

Requires Improvement

The service was inconsistently caring.

People were looked after by staff that treated them with kindness and respect.

People were supported by staff that promoted and respected their dignity and maintained their privacy.

We concluded that, on balance people were inconsistently able to express views and be involved in their own care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not personalised and so did not always meet people's individual needs.

People and their representatives may not be systematically involved in planning their care. Staff did not always know how people wanted to be supported.

Activities were developing but were not always well planned in line with people's interests.

People's complaints and concerns were taken seriously. People's experiences were taken into account to drive improvements to the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The new registered manager was promoting an open culture. The registered manager was approachable and working hard to define roles and develop a clear working structure within the staff team.

Quality assurance systems were not driving improvements and raised standards of care. The provider had not successfully grasped the issues that require improvement within this home and resourced them accordingly.

St Marys

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 took place on 12 and 19 May 2016 and was unannounced.

The membership of the inspection team consisted of two inspectors, an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case experience was with older people. In addition we were accompanied by a specialist adviser. Our adviser was a nurse and had experience of working with older people and knew their specific health needs.

Information was gathered and reviewed before the inspection. This included statutory notifications. These are events that the care home is legally required to tell us about. We had also spoken to local professionals who had contact with the service. We had action plans received from the last inspection.

The methods that were used included talking to sixteen people using the service, five relatives and friends or other visitors, interviewing twenty staff in all roles at the home, Two volunteers, pathway tracking, observation of care and support and reviewing seven care plans. We also examined other records in relation to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 19 June 2015, we found that the provider had failed to take action to ensure people's health and welfare was not put at risk and action taken to protect people from the risk of harm. The previous registered provider sent an action plan to us explaining the improvements they were putting in place. This new provider took over responsibility for that action plan as the legal entity remained the same. Whilst we found some improvement at this inspection, further action is required.

Risks to people were not consistently and effectively assessed and managed to keep people as safe as they could be. One person on, Constable unit who had a very large bruise across both eyes told us, "No one helps you here." We found another person with similar bruising to their face. Therefore we looked at the accident records and incidents that had occurred and how these had been managed in terms of review and mitigating future risks within care plans. We spoke with staff about this. We concluded that in both of these unrelated incidents where the people had fallen and sustained a head injury there was an inadequate response, monitoring and medical help being summoned. In one case it took over seven hours for the person to see a medical professional or have a medical assessment. There was no evidence in the person's records that they were observed following the incident. The post fall/accident observation tool had not been completed. When we asked staff what they would observe they were not able to give a competent and confident answer that demonstrated that they knew what to observe for following a head injury. In the second case when the person returned from the hospital late evening they went to bed and staff in the daily notes recorded, 'slept all right'. The sleep and rest regular checks completed through the night had not been completed as was the case the previous week when no head injury was present. This person's falls risk assessment had not been reviewed and updated in light of this serious incident. We concluded that risks to people with regards falls prevention and intervention was not sufficiently balanced.

A new person admitted to the home had an assessment that clearly said the reasons for admission. This included stating that the person had lost weight whilst in hospital and had a reduced appetite. There was no Malnutrition Universal Screening Tool [MUST] This is a risk assessment to identify adults, who are malnourished, at risk of malnutrition. There was no Waterlow completed in their care file. A Waterlow is a risk assessment for improving care and prevention of pressure ulcers/bed sores. The assessment had identified that the person was at risk of urinary tract infections and at risk of developing cellulitis. Neither were adequately assessed or any risk assessments or prevention plans put in place. This lack of guidance for staff left people vulnerable to poor care and timely intervention.

We found that one person had a serious incident of choking and an accident form was completed. When we looked at this more closely this was because the person had been served food that was inappropriate [toast] This was despite the person being assessed by the Speech and Language Therapist [SALT] and them stating in December 2015 that the person required a soft, moist diet and stage one thickened fluids. Not all staff were aware of what foods constituted 'soft' and the person was still being served sandwiches. One key reason was the transition from old to new care plans and the associated risk assessments and professional advice had not been pulled through in to the new care plans. We fed back that this was a high risk and needed to be addressed.

This was a breach of the Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People believed that there medicines were safely handled and administered. One person said, "I don't know about my pills, they just dish them out at meal times". However we found that medicines could be more robustly managed to keep people safer. A member of the inspection team was walking past a table near the dining area and noticed a small medicine cup and 1 and ½ small white pills lying on the floor. We immediately pointed them out to a member of staff who picked them up and said "I have no idea who they belong to". An audit of medicines was being carried out each day of medicine in the controlled drugs cabinet. When we looked in the controlled drugs cabinet we saw a dispensary bag containing medicines, which had been dispensed on 9 May 2016. This was 3 days before our inspection. The medicines had not been booked into the home and also the daily audit of medicines had failed to identify this information. We discussed this with team leaders and the deputy manager and staff thought that other staff had booked these medicines in but nobody could account, that this had not been detected by the daily audit.

We saw that 15mg+500mgs Co-Codamol medicines had been signed as given on Wednesday of week 1 in the Medication Administration Record (MAR). However the medicine was still in the blister pack in which it was supplied. This meant that the medicine had been signed as given but in fact it had not. We spoke with the staff on duty who were very upset to learn of this error but could not account for this situation.

This is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (part 3).

The medicine room was locked at all times when not in use and the medicine keys were carried by a senior member of staff. The clinic room was of an adequate size, clean and tidy. Temperature readings of the room and fridge were taken daily and showed the recorded temperatures were within acceptable limits. There was a policy and procedure in place for administering and storing medicines. We saw that staff had recorded information regarding the return of unrequired medicines and this was following the laid down procedure of the service.

People were not as safe as they could have been with regards to avoidable harm and abuse. Not all risks had been mitigated and not all staff were effectively trained. People we spoke with at the service said they felt safe. One person told us. "Yes I feel safe, I have my own key." Another said, "Nobody dares treat me badly." One person told us, "I know the staff and it is a lovely place." A member of staff told us. "People are safe here because we know them well." Three of the team leaders we spoke with had all been promoted from care assistants in the past and had worked for the previous provider for many years. As a result they had built up a personal knowledge of the people in their care.

One member of staff told us. "We have had training from the previous owner and training is planned with the current owner." They were aware of the policy and procedure for safeguarding had changed from provider to provider, but they were similar and the key points had not changed. They felt confident to report any issues or concerns to the management and that this would be reported to the safeguard team. As a team leader they were aware that they may need to support care staff to report information on to the management and also to report information themselves in the manager's absence. A team leader told us. "I cannot understand how anyone could hurt a vulnerable person, but it can happen and if I saw anything I would report it straight away."

We spoke with the deputy manager regarding how to keep people safe. They confirmed that the provider had a policy and procedure. They were confident that staff had been trained under the previous provider

and training with the new provider was being arranged. We saw that the first training had been arranged for 21st June 2016 and further dates for two to three staff at a time were arranged through the next few months. This meant that 21 staff had been booked onto safeguard training up to 23 September 2016, with the new providers training department. Although we understand that training was being provided in a priority order from the time that the staff member last received training from the previous provider. We noted from the training scheduled we saw, that the provider recognised that the safeguarding training was compulsory. The training program had the names of 50 staff which meant that with the current arrangements less than half the staff would have received the safeguarding training by the end of September 2016.

We asked people about voting in the upcoming election and three people confirmed they were registered to vote. One person said, "I could vote, I'm not bothered whether we stay in Europe or not".

The manager had been working hard to recruit staff and had filled the majority of staff vacancies. This was an improvement on the previous inspection as staffing numbers had increased.. We did not see the previous impact of lack of care and support as seen at the last inspection. Peoples needs were seen to be met in a timely fashion. People were generally positive about staffing numbers. Only one relative said, "I think my [relative] is safe here because I visit everyday. There are enough staff in the building but not always on Constable unit throughout the day." They felt that at times the Constable lounge and dining area was left unsupervised which they felt this was a risk to people. Staff believed in their experience there was sufficient staff. One member of the care assistant staff told us. "I think we have enough. It is always busy and things to do which I like, but we are not rushed." A team leader told us. "When we are busy we can ask for help from the other unit, so no problems we work as a team." Another team leader told us. "Some days we could do with another member of staff to help, you never know until the day starts and depends upon how people are." We asked what they did in those circumstances and they said they would speak with the manager and assistance from the other unit would be arranged to support.

We saw the staff rota and this comprised from the information of the dependency tool used to determine how many staff were required. The deputy manager told us that as the care plans were being reviewed and rewritten and they would ensure this information was taken into account regarding the dependency calculations.

There was a team leader vacancy on night duty and these 3 to 4 shifts per week were being covered by staff of that rank doing extra shifts and using agency staff. The manager was aware from our discussions this was a priority and was working to appoint a member of staff to this position. We noted from the rota that the deputy manager had been fulfilling some of the night duty vacancy to cover the service.

The rota clearly identified a member of staff to provide 15 hours of one to one support for a person using the service. We spoke with the person and member of staff and they explained to us the one to one support that was being provided. The care plan was not specific with regard to when the support should be provided or in details of what was required. The service was continuing to provide the support as per the previous provider of giving support on four days per week in three blocks of four hours and a further three hour session. We could see that the person providing this support was not included in the staffing compliment for the rest of the service. We concluded that staffing levels were being consistently maintained including one person allocated one to one support.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of 19 June 2015, we found that staff training and development was not sufficient to show that people's healthcare conditions were fully understood by staff so their needs were recognised and met consistently. At this inspection matters had not improved sufficiently.

People were confident in the skill of the staff and. One relative said, "She has a chest infection and has had several falls, they are looking after her really well". However, we were not confident that staff had the skills to perform the roles they had effectively. There was evidence in the records reviewed that the staff did not have the knowledge and skills to respond to the needs of the people. Staff had diligently recorded incidents of aggressive behaviour and their intervention for one person. The form asked if the intervention had been successful. Staff had repeatedly written 'no', but the same intervention was repeated by staff. An example was as follows: 'when trying to stand [persons name] from the wheelchair into a comfy chair, [person's name] punched me twice in the stomach'. The record reported the: 'punching out at care staff'. Carer stated, 'no you don't punch people'. Under if effective the record stated 'no'. There was evidence from these examples that staff were not being effective in managing distressed behaviour and it is evident from their responses to the behaviour that they did not have the knowledge or skills to respond in a manner that would reduce the behaviour.

The staff interviewed were not able to tell us how they would effectively observe people who had suffered from a fall. In the records of a person who had suffered from a significant fall, which included bruising to the forehead, no on-going observation was made to ensure that her condition did not deteriorate. It should be noted that this person was also receiving, Warfarin treatment which can increase the risk of bleeding. Staff spoken with did not understand the significance of this. Staff confirmed they had received basic first aid. They told us that for injuries they would apply pressure to wounds or a cold compress. They told us that some team leaders were planning to complete a three day first aid course. We found that staff did not consistently have the skills and knowledge in relation to diabetes management and the understanding and skills relating to blood glucose testing. One team leader was aware of which people had diabetes, when asked, would they recognise the signs of a hypoglycaemic attack they said, "I am not sure to be honest, I was trained a while ago."

Staff did not display a consistent knowledge and understanding of consent and decision making [more details in the paragraph below]. This coupled with the behaviour of the manager who was keen to keep responsibilities close to them and did not display to us confidence to delegate tasks. They informed us they were not confident in the senior teams ability within the home. We are aware of training scheduled for staff and systems of supervision being implemented in the near future. We are sure that this will be addressed in time, but on balance found this was too high a risk at present for people living within the service. In addition staff had some knowledge on safeguarding people from abuse, but the timeliness of this update training is in question as it does not match the providers own expectations of staff. We concluded that staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and support to people safely and to an appropriate standard.

This was an on going breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (part 3).

One member of staff told us about the induction they had received when first starting work at the service. They had undertaken some training with regard to keeping people safe through correct lifting and handling techniques. During their induction they had worked with team leaders and other experienced care assistances on a shadowing experience. Shadowing is when the new staff member is not included on the staffing rota and spends time working alongside colleagues to support them learn the role and to get to know people. The person told us. "I enjoy working with older people, I have great respect for their knowledge and experience." Three members of staff told us that they had received supervision in the past and were aware of what supervision is and how supportive it is. One person told us. "We can talk with the senior staff who are approachable and helpful, but we have not had planned supervision for quite some time." The staff considered that they were supported but did not have formal supervision and were not aware of any annual appraisals having been planned. From our discussions with the management team of manager and deputy we were aware that supervision was planned and they supported staff at present as matters arose.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who may need their liberty restricted to keep them safe and provides protection for people ensuring their safety and human rights are protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The manager was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. The manager told us that they had revisited the work of the previous provider and now had five DoLS approved. They were keeping this situation under constant review. We spoke with staff about the Mental Capacity Act 2005 and they were aware of the Act but their information about DoLS and best interest meetings was not complete. When we spoke to people about decision making they gave us a mixed picture. One person said, "I like to look after myself and they allow me". A different person said, "I just put on what they give me". But one said, "We are not really supposed to visit people in their rooms, it's a way of controlling you". A different person said, "I don't like living here, I don't like the fact that you can't just walk out, they like you to be closed in, they control you in a very nice way". People were not always sure they could have a key to their room. We saw that one person did have a key and kept their private room locked. One person said, "No, no I haven't got a key, I would like one".

Staff confirmed they had received training in the past under the previous provider and were aware that further training was being planned. We spoke with a team leader who had been asked and was looking forward to commencing work on reviewing and rewriting care plans. They were knowledgeable in the area of DoLS and said they would be paying particular attention to this when reviewing the plans and would seek the advice of the manager for anything that was not clear. Our conclusion was that staff had some degree of knowledge, but this was not effective in terms of written information or from the experience that people told us about. The provider had not consistently assessed and checked the competency of staff in the area of consent, decision making and their understanding of best interest decisions.

People on the whole spoke positively about the catering. One person said, "You shove it front of me and I'll eat it". Another said, "It's alright dear, what I like is milk and they give me plenty of that, they don't fuss about and bring you stuff you don't like". A different person said, "They give me a choice every day, sometimes they give me too much". A relative told us, "She loves soup so I bring it in and they cook it for her everyday".

At our last inspection of 19 June 2015, we found that people were placed at risk due to staff not displaying

knowledge and providing appropriate diets and fluids to people. At this inspection matters had not improved sufficiently and significant risks remained.

We were not clear about what food was on offer on the day of our visit. In Constable the menu was written in purple chalk on a blackboard which made it very difficult to read. The menu for Gainsborough and Waterhouse units was placed in frames outside the dining room were three days out of date. We were informed by a member of staff that people chose their meal at 10o'clock that day and therefore were able to choose what they preferred on the day. Lunch time in Constable was relaxed and well-paced for people. Observation showed that people received sufficient to eat and drink. Staff were observed ensuring people had plenty to drink throughout the day. There was juice available in the dining rooms. Staff were observed assisting people to eat and drink where required. We did feedback that earlier preparation could have improved matters as staff had to make repeated journeys out of the dining spaces to retrieve aprons, juice, and other equipment. Also the food trolley once the meal had been served left the area – so no one was able to be offered a second helping. Our observation in Gainsborough and Waterhouse units was that people sat in silence throughout the entire meal. One person told us, "The silence at lunch, there is no need for that, they [other residents] need to be pulled out of themselves". This could be reflected upon by the management team because whilst we observed a person being offered an alternative as they had not eaten any of their meal and a second encouraged to eat more, as they had not eaten much of their meal. We also saw three people having meals that they had hardly touched taken away with no interaction at all. Whilst people were offered a choice of desert, no choice of flavours for yogurt was offered. We saw that there were six food and fluid charts in operation for people living on the Constable Unit. Each day information had been recorded regarding the food and fluid intake of the person. On Gainsborough and Waterhouse units a member of staff was completing peoples food charts even though they had not been present during lunch service. Therefore we question the accuracy of this information.

Two members of staff in Gainsborough and Waterhouse units spoke of what food should be eaten by people with diabetes (low sugar) and knew of the symptoms of hypoglycaemia. They also informed us that people get offered all puddings and it is their choice whether they opt for one with a high sugar content. We spoke with a person with diabetes and they told us. "They always offer me pudding, sometimes I have it, they shouldn't do it really" and they explained that they were diabetic. The chef was interviewed confirmed that the cakes, cheesecake, ice cream, biscuits and deserts were all made with sugar. We examined the food charts for a person who had their blood glucose monitored. It showed that they consistently ate unsuitable foods such as cake, jam sandwiches, ice-cream, cheesecake and biscuits. A variety of options suitable for people with diabetes should be available to people without compromise to their health and staff need to understand the implications of their actions in offering such foods as being suitable.

We have already referred to the inconsistent approach to supporting people who need support with food. In so much as people did not consistently have Malnutrition Universal Screening in place and therefore people at risk of malnutrition was not known by staff and advice from the Speech and Language team was not always known and followed by staff. This is high risk.

This is an ongoing breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (part 3).

People were not consistently supported to access appropriate healthcare and maintain good health. People were registered with a GP. The district nurse visited regularly. People said they could request a dental visit. One person said, "My dentist visits me here, my son arranged it". We found that records indicate that there have been a significant number of falls reported. There was evidence that people have not received appropriate observations and timely medical intervention following these falls. One person did tell us their

experience; "I fell flat there, they all rallied round and that was very nice". However, we found risk assessments and any subsequent action was not always in place to prevent a similar occurrence. There was no cohesive falls prevention strategy that staff were aware of.

A person with diabetes had not had their blood glucose levels measured twice daily and there was no evidence in their records that they was being reviewed with regard to monitoring of vision or that they was being seen by a chiropodist. Both of which are key to monitor for a person with diabetes. This meant that people living with diabetes were at risk in this service of not having their care needs monitored and met.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 19 June 2015, we reported that one person told us they were not being supported to meet their spiritual needs fully. This was because they could not attend a place of worship and they were not visited by a person of that faith. We followed up on this line of enquiry and spoke to three people and this is what people told us. "I'd love to go but it hasn't been offered". And "I'm a church goer, I'd like to go, I have made a fuss about it but it dropped nowhere". And "I would love to get there (church) but no I wouldn't like to ask them". Therefore we conclude that the individuality and expression of faith is not routinely addressed within this home.

Two relatives told us that they visited their relatives most days. However despite this they had not been aware of the significant change in Constable that dining rooms were converted into lounges and vice versa. Although they did not object to the changes they felt that it was very disappointing that they had not been involved in this matter. We looked through the recent relative minutes but could not see this change had been mentioned at a meeting. We did find however that people at the service had been consulted on the moving of the television from the lounge at the front of the home to a smaller snug – specifically a TV room. These minutes also showed us that relatives were listened to and were able to bring up a wide variety of topics and seek answers that were then actioned and updated in a different colour for people to see. This showed us that suggestions by relatives were taken seriously and addressed promptly. In addition we saw the minutes of residents meetings. This demonstrated to us that those who attended were quite happy with the dining room changes and that they had made several suggestions around how to improve the food on offer. Two people we spoke with from Gainsborough and Waterhouse units about attending residents meetings were candid and offered the following views: "No I don't go because I didn't know about them". And, "No they don't listen, they ask your ideas, you can put things forward but they ignore it".

In people's care plans we saw that people were consulted and involved in writing their care plans. In one case we saw that a specific meeting had been held with a social worker to enable a decision to be made relating to finances. We concluded that, on balance people were inconsistently able to express views and be involved in their own care.

Throughout the inspection, we saw staff treat people with kindness and compassion. This included asking people how they were. People told us that staff were kind. One person said, "They all look after me, they do their best for me, they are always polite". And another said. "They were very kind, I've only heard good things about them". Other people were a little more circumspect in the reply when we asked. One person saying "They look after you because they have to, are they kind, yes I suppose so". Another saying, "They are friendly, very good as far as that is concerned, very considerate, some can be a bit short". A different person said, "All the people who work here are nice, even if they are not my sort of person". A volunteer told us, "From what I see and hear the staff are very caring".

We observed good interactions between staff and people demonstrating caring and meaningful relationships with good knowledge of people's preferences. We observed a staff member interacting with a person who was distressed. She was seen to be very gentle and was observed kneeling down and speaking

quietly to the person and offered reassurance. The same member of staff was seen to manage a situation where one person was disturbing another. She was seen to ensure that both persons were safe and quietly and calmly assisted the person to a safe place.

We observed that in most cases staff treated people with dignity and respect. Interactions between staff and people were respectful and polite. We saw staff knocking on doors and not entering until they had been invited to do so. A relative informed us that they had found their relative in stained pyjama clothing probably as a result of the breakfast that morning. They were disappointed with some staff who had said that their relative did not have enough clothing when in fact they did and we were shown the wardrobe with sufficient day clothes for that day. They were having to wash and iron their relatives clothing as the service had not had its only tumble-drier which had been out of action for a few days being repaired. The relative also pointed out that the top draw of the chest of draws in their relative's room was broken. This they told us had been pointed out some two weeks previous and although they have asked for progress with replacement or repair. The furniture remained broken. They did not wish to complain but were disappointed in this lack of respect for their relative. When this was explained to managers they agreed to immediately address these concerns and agreed that this was unacceptable.

People told us that they were able to have visitors at any time and appreciated that they could entertain them in a small lounge and they were able to make themselves refreshments. One person said, "It is lovely to offer your guests a cup of tea when they come". One person told us how they appreciated when they went to have their hair done; staff took the opportunity to clean their room. We did speak with two relatives who were frequent visitors to the home and they told us, "They have always made me welcome, and I can come at any time". "They always give me a ring and let me know when there's a problem".

When we examined care plans we took the opportunity to see if people's wishes around end of life planning had been completed. In the records we examined non had been completed. We did however find that Do Not Attempt Cardio Pulmonary Resuscitation [DNACPR] documentation had been appropriately completed in three cases.

Requires Improvement

Is the service responsive?

Our findings

The management of the service had decided to focus upon transferring information from the previous providers care plans to the new providers. This had commenced and we were told that the service intended to do some four care plan transfers per week upon our first inspection day. However the service staff could not provide us with a date of when this would be completed. We understood that on our second inspection day, that additional resources were to be focussed upon this transfer and update of information. However we still could not be sure of the extent that relatives would be involved, when this would be completed and how the plans were to be reviewed as accurate and future checking process. We fed back that we believed there to be risks in this meantime as staff were not clearly informed and aware of people's needs to ensure they delivered the correct individualised care that was responsive to people's needs.

We were not assured that people led the lifestyle that they would positively choose. There was some negative feedback that included, "We were going to have something to do every day but that never happened". And, "We have to make our own pleasures, they don't offer to take you on outings outside". One person said, "I stay in my room but my mind is slowly closing down". A different person saying, "They are kind and good (Staff) I just feel a bit lost, you don't have a conversation with anyone, not even about the weather". Some people were slightly more optimistic and said, "Unless they have an open day I spend all my time up here, no I don't get bored as I have my own private telly". And, "I don't like mixing with people, they don't interfere, they keep me supplied with plenty of books". A relative told us, "They do dancing and [my relative] enjoys hoopla. When they take the pictures down off the wall they put them in a scrap book for each person".

We were aware that two staff had very recently been appointed to the roles of Activity Coordinator. We observed staff writing the activities for the morning and afternoon on the board at 1.45 pm. We spoke to an Activities Co-ordinator. They stated, "We do loads, we have organised the open day, we are having a dog show, we have poster up". We asked about activities for people. They replied, "We have a knitting group, we do 1-1 time, life story work, we walk up round the field, to the co-op". We asked who decides these activities? The reply being, "We do, but we have asked them all what they like doing and have got a list". They informed us they had been responsible for activities for four weeks. On the day of our visit the hairdresser was visiting and had styled several peoples hair. They told us, "Residents love the 1-1, it gives them a bit of time" Matters were potentially set to improve, but we have no evidence to gauge that yet.

There was a comprehensive complaints procedure in place for people to access. We spoke to the registered manager and found their approach was open to receiving complaints and that they saw this as an opportunity to listen and improve the service on offer. The manager kept a comprehensive log of any complaint received and the investigation and responses made to people. We did not see any repeat matters occurring since the new manager had taken over. We enquired as to how people could make their concerns known and the manager believed they were visible as they were at the service daily and regularly visited with people. A comment box from the main entrance was in the process of being replaced for a more suitable looking box. People could either telephone or ring the home with their concerns. However, one person said, "No I don't know how to complain, I wouldn't know how to do it". And a relative fed back to us, "We have

had lots of clothes go missing, even though it has her name on, we have said something but it still goes missing". Laundry was a subject brought up at staff meetings previously as not being as efficient as it could be. In addition, a minority of relatives had leapfrogged over the registered manager in post and had not been encouraged to use the systems in place to resolve matters at a local level. These matters of developing a more effective complaints management were fed back at the inspection.

Requires Improvement

Is the service well-led?

Our findings

We found a registered manager that was popular with staff who told us that they respected them and that they had improved matters at the home. The local authority told us they had confidence in the manager and believed given time they would be able to improve standards. A person at the home said, "I can't remember her name, she pops in and see's the lady next door and then she pops and sees me". Other people were not as confident in knowing the registered manager. The registered manager was quick to engage with CQC and applied very soon after they took up post.

They have been diligent to keep us informed of developments at the service and this has included notifying us about significant events in line with the legislation. The registered manager was open and honest with us about the current situation within the home but also was able to tell us clearly the developments made since they started in the last four months. They had completed an environmental audit, disposed of some unwanted and broken fixtures and fittings. They had purchased several basic items such as crockery, bedding and a dishwasher – all of which people and staff had been requesting for some time. There were plans to decorate parts of the home and a maintenance person was being appointed. People at the home had been involved in recruiting this person. There was now a workforce of regular staff in place as the manager had been actively recruiting. Consideration had been given to the staffing structure within the home and this had been developed with new appointments that the registered manager believed would better suit the needs of people. There were plans in place to develop the skill and knowledge of staff. All the care plans were in the process of being reviewed and transferred on to the Anchor paperwork who owned this care home group. Whilst this manager had only been appointed in the last few months and recently become registered, the provider had purchased this care home in late 2015. They have had over six months to improve this service and were fully aware of our public reports and previous concerns relating to this service.

Our concerns about this service stem back some time. We had visited the service on 09 September 2014. Compliance actions were set for breaches in Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 - 18, 9, and 10 Regulation 18 CQC (Registration) Regulations 2009. This was around Good Governance and safe care. In addition we took enforcement action and issued warning notices for breaches in Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Regulation 13 and 10. This related to the care and welfare of people and Good Governance.

We inspected again in June 2015 and found breaches of five Regulations relating to person centred care, safe care and treatment, nutrition and hydration, good governance and staffing. We were following up on these breaches in regulation at this inspection and would have expected a defined improvement led by the provider given this history and timescale.

Anchor is a large provider with systems and processes in place that have been effective in their other services, but in this case those systems had not been followed. We were told of audits and systems called an Excellence Tool that is based upon our five key questions found in this report. However this had yet to be completed by an Anchor representative We were also told that a representative from Anchor would have

visited monthly, but we were unable to see monthly reports completed. We did see a three page report of actions completed in February 2016, but this was not comprehensive and did not state who had completed this, nor who was responsible for action or any timescales. What we did see was an action plan based upon an internal inspection report from November 2015 and our previous inspection findings. This document has an action plan colour coded and green indicated action completed. The report was 28 pages long and identified over 80 finds with numerous more actions points for each finding. Green action that indicate complete were less than 50% and based upon our findings at this inspection a number of these were not correct. Such as matters relating to care planning, suitable food and fluids for people, peoples social and emotion needs adequately assessed and delivered, and the comment box not available in the entrance. Therefore we would disagree that these requirement in regulation had been addressed by the provider.

We have found risks to people were not consistently and effectively assessed and managed to keep people as safe as they could be. Falls prevention and intervention was not sufficiently balanced. Malnutrition Universal Screening Tool [MUST] that identify adults, who are malnourished, at risk of malnutrition and Waterlow, a risk assessment for improving care and prevention of pressure ulcers/bed sores were not systematically completed for people at risk. Individual care needs that were known about such as urinary tract infections and cellulitis were not part of care plans for staff to follow. A person was given toast and choked despite being assessed in December 2015 by Speech and Language Therapist [SALT]. Staff were unaware of suitable foods to offer people to meet their dietary needs. I.e. 'soft, moist diet' as assessed by SALT. People living with diabetes were placed at risk of being given inappropriate food choices and a lack of access to routine health screening specific to people with diabetes. Medication was not robustly managed to keep people safe.

Staff did not have the skills to perform the roles they had effectively. They were not able to effectively manage distressed behaviour. Staff did not consistently have the skills and knowledge in relation to falls and diabetes management. The provider had not consistently assessed and checked the competency of staff in the area of consent, decision making and their understanding of best interest decisions.

We have found that the provider have not adequately assessed and identified the short falls we have found, delegated resourced and improved this care home quickly enough for people to safely live here.

This is an on going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Since the inspection the provider has written to CQC and confirmed that they would not admit any new person to the home. They agreed with CQC that they need time of consolidation and to improve the safety and quality of care afforded to people currently resident. The manager has sent us an up to date action plan. This showed us that the registered manager understood the verbal and written feedback given at the time of the inspection and has proactively ahead of our report started to work on issues identified. They inform us that some areas have been completed. In relation to staffing competencies and training and minimising risks to people as action is said to have been taken with regards risk assessments and care plans in relation to diabetes management and ensuring people receive an appropriate diet. We will of course re-inspect in due course to ensure people are safe and appropriately cared for.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutrition and hydration needs of people was not suitably met consistently and adequately in all cases. Regulation 14 (1) (2) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported and consistently competent, skilled and experienced to meet the needs of people in their care. Regulation 18 (1) (2) (a)