Four Seasons Homes No.4 Limited

Kingfisher House Care Home

Inspection report

St Fabians Close
Newmarket
Suffolk
CB8 0EJ

Tel: 01638669919
Website: www.fshc.co.uk

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 23 March 2016 and was un-announced.

We last inspected this service on 21 and 29 October 2014 and found it was not meeting some of the standards required and the location was rated as Requires Improvement overall. We carried out a further inspection on 5 August 2015. We rated the service overall as Inadequate as it had not made progress against the breaches identified at the last inspection and people were not a experiencing a good quality of care. The service was placed into special measures, which means the service was providing inadequate care and was given an initial six months but no longer than a year in which to improve. In addition to this we served a warning notice relating to the providers failure to comply with Regulation 18 HSCA (RA) Regulations 2014. Staffing. As we identified insufficient numbers of staff with the right skills, qualifications and experience to deliver effective care. The timescale to comply with the warning notice was 28 days. We re-inspected the service on the 5 November 2015 and only looked at one area of concern relating to the breach around staffing and whether people were receiving safe care. The service had made some improvement in this area and had partially met the requirements of the warning notice but it remained in special measures.

The service has four separate units and can accommodate up to 91 older people who require residential or nursing care and may have a diagnosis of dementia.

There is a registered manager in post. 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.

During the inspection in March 2016 we found the service was slowly improving. We found that a high staff turnover in recent months had destabilised the service and impacted on the ability to make the improvements required at a faster pace. The manager was not able to manage the service effectively as there was no support from either a clinical lead or deputy manager although we were advised during the inspection that one of these posts had been recruited too. There were also a number of nursing vacancies across the service. We observed that people experienced differential levels of care across the various units.

Care staff vacancies had been reduced to a minimum and there had been a dramatic decline in the use of agency staff which meant people felt that the continuity of care had improved. Staffing rotas and dependency tools to determine how many staffing hours were required to meet people's needs would suggest staffing levels were adequate but people's experiences and our observation identified this was not always the case. People's care was compromised at times due to ineffective deployment of staff.

People felt safe and risks to people's health and safety were well documented and steps were being taken to reduce risks to people. However staffing levels could potentially impact on people's safety particularly in relation to staff's response to call bells.

Staff understood their responsibilities to monitor people's health and safety and to reduce risk and report any concerns they might have about people's safety. Some staff felt the manager was not always approachable which could act as a barrier for them raising concerns.

There were safe systems in relation to medication practices and we were confident that people were receiving their medicines as and when they needed them by staff who were sufficiently competent and trained to administer medication.

The service was clean and organised and systems were in place to audit the cleanliness of the service.

Staff received support and training to enable them to perform their role. The induction process was robust. Training received by staff was good and induction covered how to meet people's personal care needs. People raised concerns in relation to the language skills of some of the staff which made communication difficult. Staff were being supported to develop enhanced skills and receive training around people's individual needs.

There were processes in place to support people with their hydration and ensure the risks from unplanned weight loss were effectively managed. However the dining experience for some people was poor as people did not receive adequate support around their individual needs and some people reported poor quality and choice of food. In advance of the inspection we had received a number of concerns about people becoming dehydrated, we found on the day that the service had improved how they manage people's food and fluid intake.

People's health care needs were clearly documented and showed us how staff were meeting people's needs. However concerns were expressed by relatives and people using the service about some staff not being familiar with people's needs which increased the risks of people not getting their needs adequately met.

Staff had a good understanding of legislation relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

Overwhelmingly people were complimentary about the care and support they received from staff and staff expressed frustration at not being able to spend more time with people. The service worked inclusively with family members, visitors and other health care professionals. They also engaged with volunteers to help ensure people's emotional and spiritual needs were met.

Staff tried to deliver care according to people's assessed needs and wishes but this was sometimes compromised due to staffing levels. However care observed was compassionate and delivered in a calm, engaging way. They was a great deal of laughter from people and staff at the service and people appreciated being supported by cheerful staff.

People were involved and consulted about their care but it was recognised that some people found it hard to engage in care planning and it was not always clear how their views were taken into account.

There was an established complaints procedure which was understood by people and there was evidence that complaints/ comments were acted upon in a timely way to improve the service.

The service tried to meet people's individual needs and provided lots of different activities. However some people were not engaged throughout the day and there did not appear to be sufficient opportunities for everyone to have activities that were appropriate to their needs.

Care plans were mostly up to date and showed people's needs once assessed were regularly updated to ensure the plan of care remained relevant to their needs.

The service was well managed but we identified gaps in service provision due to vacancies and change in staffing and not having an effective management team in place.

Communication was improving and we found records reflected people's needs with sufficient management oversight.

Audits were regularly completed to assess the quality and effectiveness of the care provided but we felt these need to be strengthened to ensure everyone experienced a good standard of care and pockets of good practice are the norm across the whole service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

There were not always enough staff with the right skills and experience to meet people's needs although this had improved.

People using the service felt safe and there were good processes in place to manage risks and report concerns.

There were safe systems in place to ensure people receive their prescribed medicines as prescribed.

Is the service effective?

Requires Improvement

The service was mostly effective

Most staff had the necessary skills to deliver effective care but some lacked experience and staff supervision was not as regular as it should be with regard to the service policy.

People were not always supported to eat and drink in a way appropriate to their needs. Comments about food also lead us to believe people's preferences and tastes were not always accommodated.

People health care needs were being largely met but there was some concern about accuracy of records particularly in relation to fluid intake.

People were supported appropriately by staff to make decisions about their health, care and welfare.

Is the service caring?

Good

The service was caring.

People told us they felt safe and well cared for and enjoyed the interaction from staff.

Most people where able were consulted about their care and made decisions about how they should be cared for.

People's safety and independence was promoted as far as possible.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

A programme of activities were in place and these benefitted some but not all people using the service.

Care plans were informative and were actively reviewed to show changes in people's needs.

There was an established system for people to give feedback which was acted upon to improve the service as required. However not everything we identified had been identified by the service.

Is the service well-led?

Requires Improvement

The service was mostly well led.

The culture of the service was changing but some staff did not feel well supported and the experiences of some people was not reflected in the services own quality assurance systems.

The service was developing the professionalism of the staff which was only compromised by staffing vacancies and limited support for the manager- in terms of no clinical lead or deputy manager currently in post to help stabilise and strengthen the service.

There was a system of audits and quality assurance to monitor people's safety, well-being and experiences of the service This enabled the service to make reasonable adjustment to improve the experiences of people using the service. This needs to be strengthened further.

Kingfisher House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 March 2016 and was unannounced. The inspection was undertaken by three inspectors, a pharmacy inspector and 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. Our expert had experience of older people and dementia care.

Before our inspection we reviewed all the information we held about this service including previous inspection reports and the action plans they subsequently submitted. We received feedback from the Local Authority, the safeguarding teams and reviewed any notifications that we had received. Notifications are important events the service is required to tell us about.

During our inspection we carried out direct observation of practice of each of the units and we spoke with twelve people living in the service. We spoke with eleven members of staff, including senior staff, ancillary staff and care staff. We spoke with seven relatives and a number of health care professionals. We looked at room charts, six care plans, carried out a medication audit on two floors and looked at other records relating to the running and management of the business.

Requires Improvement

Is the service safe?

Our findings

At our last inspections on the October 2014 and August 2015 there were not enough staff and staff were not sufficiently deployed to meet people assessed needs. This was a breach of Regulation 18. In August 2015 we served a warning notice to ensure that the provider took the right action to address the identified concerns. We inspected the service again in November 2015 and found the manager had made significant progress in recruiting staff and the organisation had a member of staff specifically employed to look at recruitment across the Providers home's.

However during the inspection on the 23 March 2016 we still had some concerns about the staffing arrangements in some parts of the service and whether there were sufficient staff to meet people's physical care needs and promote people's well being. We looked at staffing rotas and the dependency tool used by the service to determine how many staffing hours they said they needed to meet people assessed needs. The service had the number of staff it said it needed and in some cases over the number of designated hours. However not everyone had their needs met in a timely way or their care delivered according to their expressed wishes. Through observation we saw that people had to wait for support or did not get the support they required. Social activities provided only reached a small number of people. 9% of people using the service were engaged in planned activities throughout the whole day.

Agency staff were still necessary to cover a number of nursing vacancies but the manager was confident they had recruited to nursing posts and were just waiting for all the appropriate checks to come through. They told us a new clinical lead was starting in April 2016 which they felt would help. They said they had a number of new staff on induction and when they had sufficient experience this should help regular staff.

People using the service were complimentary about the staff working at the service although commenting on the number of new staff and the staff that had left in the last year. One relative told us, "The turnover of the staff has been high and it has been hard on my relative as she gets to know the girls and then they leave." Another person said, "The staff are really busy, particularly in the morning, with the buzzer going all the time." We asked people if they rang their buzzers did staff come quickly. One person said, "It depends, no always."

On the day of our inspection we inspected the four different units. In the main building kingfisher down is mostly residential and Kingfisher up is for people who require nursing care. There is a separate building slightly away from the main building called the Spillers unit. Spillers down accommodates people living with dementia, and the first floor accommodates people living with dementia who require nursing input. Each unit was staffed according to people's assessed needs. We found the nursing units were busier and people did not always receive care in a timely way or given sufficient attention for their needs. We also found people's and staffs experiences differed according to which unit they were based on with pockets of good practice which did not appear to be shared across the whole service.

On the day of our inspection all the staff working were permanent. The service had made good progress in terms of their recruitment. Permanent members of staff had replaced agency staff. Staff were now allocated

to specific units within the service so they could get to know people's needs and ensure consistency. However in terms of consistency we were given different accounts of how each unit functioned and how well people's needs were met.

On the Spiller unit, (nursing floor,) there were three staff and one nurse on duty but staff told us this was not always so. Staff told us of a recent incident that occurred and said they required support from a nurse but there was no nurse working on the floor. They said they had to fetch a nurse from another unit which caused delay. One relative told us "I think the home is very good but am sad at the changes of staff. There is no regular nurse on Spillers upstairs and the agency nurses do not know the patients." They told us about a day when all staff working on Spillers unit had been there for less than a year and although kind, were inexperienced. We also had concerns raised with us about the support people received at night and how care staff could not always respond quickly to call bell because they were busy helping other people.

Throughout our observations we saw that staff were busy throughout the morning and not always able to respond to people's needs in a timely way. As we arrived we saw that one person was very anxious to go back to their room after breakfast and told us they had been waiting 25 minutes. A staff member was not able to walk them back to their room as they had two other people who could not be left without supervision. This situation went on for a further 10 minutes. The other staff were busy supporting other people who they could not leave. This situation was very difficult for all concerned, including the staff member. The person told us this had happened before.

The deployment of staff at lunchtime was poor and led to a poor experience for some people who used the service. One care assistant was observed helping three people to eat their meals, going from one to another. This was not dignified for people who used the service and was very difficult for the staff member who coped admirably. One care assistant was on their own with six people in the dining room, only one of whom could independently eat their meal. There was not effective deployment of staff.

Spillers on the ground floor is a service for people with dementia who do not require nursing. This unit seemed well managed. We observed positive, cohesive care being provided to people and saw people were relaxed and benefitted from regular interaction with staff and visitors.

In the main building on Kingfisher up- (first floor) there were 19 people living on the unit, 10 of whom required the assistance of two staff with their manual handling and personal care needs. There were four care staff and one nurse on duty but one member of staff had taken someone to a hospital appointment so only three care staff were available. One member of staff told us that by 11:15 there were still 3 people on the nursing unit in bed not by choice but because there were not enough staff to get them up. There was little in the way of stimulation and people spend most of their time in their room. People were encouraged to come out of their room at lunch time which some did but straight after lunch they were taking straight back to their room. Social activities were being provided on the ground floor and several people went down but it was difficult to establish if more people would of joined in given greater encouragement or if not reliant on staff to take them.
Staff told us that they were expected to provide activities for people (and the activity stated for that morning was 'staff interaction') but staff told us they did not have time for this which meant people had nothing to occupy their time all day.

We received concerns about how people's needs were met at night when there as planned reductions in staffing levels which resulted in less staff delivering personal care to people

On the ground floor staff worked cohesively although not all staff were that familiar with people's needs. Staff told us It took them until lunch time to assist everyone who wanted to get up to get out of bed and some staff felt they did not have time to spend with people to chat and reassure them. A lot of people remained in bed and there was minimal social interaction. At lunch time there was quite a delay with the first person being served their lunch at 12.45 and the last person being served their lunch at 13.30. A lot of people were in their rooms and when we walked around not everyone had eaten their food which they might of done if they had been encouraged to do so.

On the day of our inspection in the afternoon we saw staffing levels were reduced as staff were either taking a break for those who had been on a long day or handing over information to staff coming on duty. This left units covered by only one member of staff. One person was calling out for the toilet and it took staff seven minutes to assist.

Staff all said that there were good and bad days and on bad days there were not enough staff. One said, "Staffing is fine and works well. Some days are bad. Today is a bad day. I am not left on my own but sometimes it's only two carers and a nurse and that's very difficult. It's difficult with just three carers four is better."

Another staff member said, "Most here [require two people to support them with moving and handling needs]. It's stressful. We are ok on a good day."

In the complaints book we saw one recent complaint about staffing levels and concerns about staffing levels had been raised consistently at staff/relative meetings for some time although it was acknowledged this was an improving picture.

We noted that personal alarms went off at regular intervals and staff did not respond as they should. We observed ancillary staff ignoring the buzzer completely which gave us cause for concern. We observed an alarm going off as a frail person was trying to get to their feet. Care staff left the adjacent room after assisting a person with tea and a domestic walked past the room. They both ignored the alarm which after 2 minutes the buzzer went to next level and then a carer came from the opposite room. We observed another person trying to stand and their pressure alarm did not go off, later they came through to the dining room trailing their bedding behind them. Staff said their alarm should of alerted them when they were on the move. It had not.

The call bell system did not have a response time which you could print off. However call bell audits had been completed but did not include information about how quickly call bells were answered. We also noted several call bells were out of reach. These concerns had not been identified by the service.

We identified a breach in Regulation 18: Staffing.

At the last inspection in August 2015 we found people did not always receive their medicines correctly and as intended. At this inspection we noted improvements in this area.

One person told us they received their medicines in a safe way, on time and were confident with staff's ability to administer medicines. Another said they had tablets on time and had tablets to help them sleep. Another said, "They leave my tablets and they know that I will take them."

During the inspection our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Staff administering medicines received training and had their competency assessed. Medicines were stored safely for the protection of people who used the service and at the correct temperatures. Audits were in place to enable staff to monitor and account for medicines. Records showed people were receiving their medicines as prescribed.

Supporting information was available to assist staff when administering medicines to individual people. For example, when people were prescribed medicines on an as required basis, there was information to show staff how to administer these medicines to people in a consistent way to meet their needs. Records showed GPs were regularly involved in the review of people's medicines.

We found that body maps were not always used to indicate to care staff where creams should be administered. We raised this with staff in the day of inspection and improvements were immediately implemented.

At the last inspection in August 2015 we were confident that staff were knowledgeable of how to protect people in their care and raise concerns if need be. At this inspection people spoken with trusted the staff and said they felt safe. One person said, "I definitely feel safe and my family know I am safe."

Staff were knowledgeable about the prevention of abuse and what actions they should take if they suspected abuse to be occurring or witnessed something of concern. They were also aware of the whistle blowing policy in the service. Several new members of staff told us that they had not yet received this training but when we checked, staff had received the training which brought into question for us how in-depth the training was.

Staff were observed to be vigilant when two people were becoming distressed and one was shouting out to the other. The staff member was patient and ensured the situation did not escalate.

At the last inspection in August 2015 we found risks to people's health and safety were not fully mitigated. At this inspection we were confident with improvements made. We saw one person was in their room and their relative told us they had a number of falls but said they were very active, always on the move but said staff kept a close eye on them and always kept them informed about any changes to their health.

We found that care plans contained guidance relating to protecting people from the risk of developing pressure sores. We saw that one person's pressure sore check form was completed twice a day for 12 areas of their body and a potential new pressure area was noticed promptly and well managed. Repositioning charts were in place and checks were appropriately completed although some records were not complete. One chart did not state which side a person had been moved to and from and did not state what setting their pressure mattress should be on but staff knowledge was good and the mattress setting was correct when we checked it.

Care plans included up to date risk assessments, manual handling plans for people who were hoisted including sling size. There were also risk assessments for falls, choking, bed rails, and fire evacuation.

One person's care plan identified them as at risk of choking. They had been referred to Speech and Language Team who had recommended that the person has a pureed diet. At lunch time we saw that this was put into practice and that staff who were helping the person with their meal gave them verbal prompts to swallow their food in between mouthfuls.

People were protected from the risk of choking as suitable risk assessments were in place and people were

provided with foods which did not place them at risk. However we found that not all staff were aware of everyone's dietary requirements as to the consistency of their food. One relative said their family member had sometimes been given food they could not manage. They said despite raising concerns this had happened more than once.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in August 2015 we found that people were not always adequately supported to eat and drink in sufficient quantities for their needs and the risks of malnutrition were not effectively monitored. At this inspection we saw some differential practice according to which unit we were inspecting so could not be assured everyone was supported as required. We also received mixed feedback about the food.

One person told us "we have snacks in the afternoon and a hot choice and sandwiches at tea time, sandwiches at 7.30 and in the night we have a snack box but also can have toast and biscuits "

We noted that people's menu choices had been taken the previous day and staff did not check with people if this was still what they wanted. Food was cooked to order so this was difficult. One person did not touch their food and because staff were busy they did not notice, When staff finally noticed they asked the person do you want something else, "Chips, pudding." We did not feel this demonstrated appropriate choices being offered to people.

Some people and their visitors felt that the food was not always appetising or appropriate to their needs. We noted that people on pureed diets had their food individually pureed and attractively presented so that it tempted people to eat.

However one person told us, "I don't get what I order and if it was a restaurant I would send the food back." They told us food can be over or under cooked. One person told us that it was all frozen food and that it didn't taste nice. They said, "you get mashed potato 365 days of the year." Another person told us that there was a choice of meals available on the menu at lunch but if you didn't like what was on the menu they weren't sure what happened they had never seen anyone ask for anything else.

Other people told us you could get a cooked breakfast in the morning if they wanted which they enjoyed. Another person said, "The food is very good and there is enough choice, always a soup on, always a salad and something hot, and cooked breakfast if you want."

One relative told us, "They give Pollock and no one likes it, they served cake from the night before and it was old. They mainly buy in frozen ready foods. Elderly need proper nourishment and I have not seen fresh fruit offered not even as a snack during the day and never seen a diabetic cake. I did see oranges and bananas in a bowl in the Spiller Up lounge."

Nursing staff monitored what people were eating and drinking. Staff told us that there was an admission tracker in people's care plans which helped staff remember what needed to be in place and by when. They said on admission people's food and fluid intake was monitored for about a week to establish a baseline of how much they would usually eat and drink and if there were any risk factors. If required people would go on to food and fluid charts and the totals would be checked and totalled up by the nurses and handed over. Where concerns were identified the GP would be contacted. A number of concerns had been raised about people's hydration which had resulted in hospital admissions and safeguarding concerns raised. The service

had followed a tracker for each person identifying those most at risk and any emerging risk. Flash meetings were held each day with staff to discuss and agree actions for anyone who needed some input. These meetings were designed to discuss and respond to urgent/emerging risks and were attended by Heads of Department.

People's weights were monitored, both on the individual units and by the management in the monthly weight report. Weights were stable in the records we saw and where one person had lost weight we saw that action had been taken to refer the person to the appropriate healthcare professionals. Staff also tried to supplement people's eating and drinking with jellies and high calorie snacks if this was needed. Staff confirmed they had received training around supporting people with their nutritional needs.

We saw some poor practice with regard to the recording of food and fluids. One staff member was seen to fill in a food and fluid chart for someone who we had observed. They had not been present while they ate their meal. We asked how they knew that the person had eaten all their meal and had a drink. The staff member told us, "He would have eaten all his roast dinner… they would have given him a drink". This was an assumption on behalf of the member of staff and therefore the record was not based on observation of what the person had actually eaten or drunk. . This person had recently been in hospital suffering from dehydration and this poor recording meant that staff were not fully informed about this person's current risk of dehydration.

Food and fluid charts were completed for people and we saw that sometimes people failed to achieve their fluid targets but this was monitored and if concerns continued reported to the GP. One person's care plan showed that they had been weighed monthly. Between 01/02/16 and 01/03/16 their weight had gone up by 6.3 kg. There was advice in their care plan for staff to monitor their weight because they had a BMI of 40 but there was no evidence to support what was being actively done to support the person.

This is a breach of Regulation 14. Meeting nutritional and hydration needs.

We observed lunch in each unit. We observed some people ate in the main dining room whilst other people ate in their rooms. Assistance given to people with their food was not always timely with some people having to wait a considerable period of time and other people getting no assistance or encouragement at all and their food going cold. Staff tried their best but there were not enough staff to give everyone the support and encouragement they needed at the time of serving their food.

We considered this a breach of Regulation 18- Staffing.

In contrast we noted on the dementia unit- Spillers on the ground floor the lunch experience was good with staff supporting people to eat at their own pace. People talked amongst themselves. Drinks were replenished a number of times and there was tea and coffee offered at the end of the meal.

At the last inspection in August 2015 we found staff received training and support for their roles but this was not always effective and there were gaps in staff's knowledge. At this inspection, March 2016 we found there were systems in place to support staff and ensure they had appropriate skills for their role. We spoke with newly appointed staff who told us they felt that their induction was good and that they felt ready to start work by the time it was finished. We saw that each person had a named mentor. They said shadow shifts were part of the induction. This meant they were supernumeracy to the rotas and supported by more experienced staff. One new staff member said, "I have been trained to do things like washing, [putting on] shaving cream [and] moving and handling." They demonstrated a good knowledge of people's needs and preferences. They had met with senior staff three times in their first week. They had also been observed

carrying out particular care tasks such as washing a person's hair, using a slide sheet and helping to put a person's hearing aids in.

Staff told us that their training was predominantly e-learning. Staff who were new to working in care had been enrolled onto additional care qualifications. They told us there was a three month probationary period and that they received one to one supervision to look at staffs training, developmental needs and well being. The manager told us staff received regular supervision and they also did flash supervisions which focused on performance issues and, or poor practice.

However the supervision matrix showed that 14 people had not received any supervision sessions yet in 2016. The manager confirmed that this was the case and that only one of these people was on long term sick leave. Supervisions were planned but there was a reliance on getting enough senior staff in post to ensure sufficient scope to provide all staff with regular supervision.

We spoke to one of the nurses who had not completed safeguarding training but they were able to tell us about their role and the role of others in terms of safeguarding, reporting and recording systems. Nurses told us what they had completed recently to keep up with their professional development including catheterisation, syringe drives, cannulisation, and end of life care.

The service were developing staff so they had key competencies and skills to deliver effective care. We were concerned that the service had its own manual handling trainers, but only two staff were trained to support well over 100 staff. The service was also investing in CHAPS- Care home assistant practioners which meant care staff received enhanced training to enable them to support nurses by undertaking some tasks a nurse might traditionally undertake such as administering medicines and taking bloods.

At the last inspection in August 2015, we found people lacking capacity were supported with decision making but we could not always be assured this was done lawfully because staff did not have enough knowledge. At this inspection Staff confirmed they received some training in the Mental Capacity Act 2005, (MCA) and Deprivation of liberty safeguards, (DoLS). They were confident that they knew how to support people with decisions about their health and welfare. There was a section in people's care plans about whether a person had capacity and if a decision had been made in a person's best interest the rational for this and who was consulted in making this decision. There was good evidence of people being supported to give their consent. Where people did not have the capacity to consent themselves we saw that the service had operated in line with the requirements of the MCA. We saw best Interests meetings had taken place to support decisions to put bedrails in place or to take medication. Appropriate people, such as relatives and healthcare professionals, had been involved in these meetings and their outcome recorded and reviewed.

People were routinely asked for their consent before care and treatment was provided. We observed staff taking time to establish if people were happy to receive a particular form of support.
People had appropriate DoLS in place and we did not see any restrictive practices for those who did not.

Do not attempt resuciatation (DNARs) were in place for some people and staff, including new staff, were able to tell us about this. DNARS had been signed appropriately and discussed with the people they concerned or nearest relative if appropriate.

At the last inspection in August 2015 we found that people's health care needs were not always met. At this inspection we saw that people had regular access to healthcare if they needed it. Records showed that people had recent dentist, chiropodist and optician appointments. The GP was appropriately involved with people's care and those with health conditions such as diabetes were regularly reviewed. We saw in one

care plan that advice had been given from the speech and language team in regards to a pureed diet and this was being put in practice by care staff at lunch time.

The service managed people's skin integrity well. We saw regular wound reviews in place for people and wounds were well managed and records we saw showed wounds to be slowly improving.

People's health was assessed and monitored and care plans reviewed to reflect any changes. For example people's sleep patterns, likelihood of depression and their pain reactions had all been assessed and strategies to manage these clearly documented.

Some feedback had been received from Health Care professionals both before and during the inspection. They were complimentary about some aspects of the nursing care. One professional said the nurses responded promptly to requests but felt they would benefit from more information in terms of severity to enable them to determine the urgency of a situation.

Good

Is the service caring?

Our findings

At the last inspection in August 2015 we found the service was not always caring. People felt well cared for by regular staff, but not all were comfortable with agency staff. People's independence and dignity was promoted but the availability and visibility of staff meant people did not always get the care they needed.

At this inspection people reported mainly very positive experiences of care. One person told us "The staff are lovely, smashing people with personalities and we rub along well. They help me dress, I go down to meals but they help me back. They bath me and they have a lovely seat and you get lowered into the water and they check the temperature and I get my hair washed. It is a nice experience and they always cover me with a towel."

A relative said, "Staff have been fantastic so kind and thoughtful and they support me and have done so since day 1 it is like an extended family and I don't have to worry about my relative."
"They are so gentle with them and call them by their first name which is our choice and they talk to them throughout the personal care they cover them up to preserve their dignity. I am impressed and it is good that they have some male carers."

One person described the care staff as "kind and helpful." Another said, "Staff are very nice. They know what people like and don't like. How we like to have our drinks and things."
"I've been here since January and believe me I couldn't ask for a nicer bunch of girls."
"We all have a good laugh."

We observed staff interacting with people in a pleasant and friendly manner although some staff said they were 'told off' if spending too much time with people.

Staff interviews were being held on a regular basis and people using the service where able were being invited to contribute to the interview process. They expressed concern about the standard of the candidate's English skills. There seemed to be no advocacy involvement on Spiller nursing floor upstairs and other than their direct care decisions, we could not see how people had been involved in a wider sense. We noticed on two occasions that people who used the service did not understand staff members who had strong accents. One person was heard to say, "I don't know what you mean" several times when they were being asked if they wanted sugar in their tea. Eventually the staff member went and got the sugar bowl to show them but the person had become quite distressed. Communication between staff and people using the service was an area of concern in terms of how staff communicated with people and offered choices in a meaningful way.

We asked people about how their made choices/decisions about their care. One person told us "I am very happy here. I do the same here as I used to do at home." One person sitting in the lounge was given television controls by a member of staff and shown how to use them.

People told us that they were able to choose what time they got up in the morning but this did not fit with

everyone's experiences with some people not having a choice as to when they got up.

One person had communication difficulties, and their care plan contained information for staff on how to communicate with them and specific information on their likes and dislikes. For example that they liked to wear their glasses at night and that they became unsettled if they were removed.
We observed signs on bedroom doors reading "Do not disturb" when people were receiving personal care.

The service was involving people using the service and resident/relative meetings were being held across the units and it was evident that people were asked about their care plan and its subsequent review. One person commented that resident/relatives meetings were not frequent enough and remained poorly attended partly due to the frailty of people using the service. Feedback from people was being sought about the quality of the service being provided.

Activity staff told us relatives were kept informed of what was happening in the service and encouraged to join in particularly with regular coffee mornings.

We spoke with people and their visitors about their experiences. One relative said, "The girls all seem nice and friendly, my relative is always clean, they bathe her and do her hair, has clean clothes and they paint their nails." "I like the friendliness and cleanliness of the place and you can have a laugh and joke with them." Another relative told us how much progress their relative had made since being here and was described as depressed and withdrawn when in their own home.

Staff were observed to be very patient and kind. We saw an excellent example of this where a carer was supporting a person, who was at risk of not eating enough, to eat. They were kind, caring, patient and were encouraging the person to try to eat something. They chatted to the person throughout and were successful in enabling the person to eat their meal even though they had no appetite for it.

Staff were seen to have easy and friendly relationships and there was a lot of laughing and joking.
During the lunchtime meal one carer demonstrated a huge amount of patience and kindness as they tried to support a number of people at the same time. They were very patient with one person who kept trying to leave the table and did not want to sit down. They took time to speak to each person and chat to them as they supported them.

We saw on Spiller downstairs, a unit for people with dementia care everyone was dressed in clean appropriate clothing, and had good personal hygiene. Staff were observed to be caring and had meaningful relationships with people. There was a good atmosphere which was inclusive. Staff were promoting people's independence and the dining experience was a good one for people on this unit.

People's privacy and dignity was maintained and promoted although we identified some poor practice around meal times. People were supported discretely with their personal care needs and staff were seen to be very respectful.

We saw that one member of staff rushed a person with their meal and did not speak to them while they assisted them. They also stood over them rather than sitting by their side. Staff were noted to be very busy on this unit and this poor practice may have been linked to this.

We looked at how staff were supporting people at the end of their life. They had a clear plan of care which set out their needs with regard to pain management and their wishes and preferences. Regular checks were in place to make them comfortable and to reduce the risk of them developing pressure sores. Staff were

able to tell us about their condition and the things that were important to them. A DNAR Do not attempt resuscitation was in place and an Advanced Care Plan decision documented people's wishes with regard to the end of their life. Involvement of appropriate healthcare professionals was in place and their relatives were happy with the care provided.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in August 2015 we found the range and frequency of social activities was poor and did not meet people's social needs.

At this inspection most people were positive about their experiences. One person told us. "I have had no concerns and if I did would go to the nurse first." "I go to lunch in the dining room if I feel Ok and if not then I stay in my room. They ask me if I want to go to Bingo or Scrabble and they do lots of things for us but they don't force you to go it is up to you."

A relative told us "I have no concerns and would recommend it, (the home) to others." One person told us that they didn't usually join in with the organised activities as they felt that they are not able to communicate with a lot of the other residents who they described as being deaf or confused.
We saw that staff encouraged people to join in with organised activities and that staff took people who wanted to join in from the nursing unit to where the activity was taking place.

The manager told us that activities for people were scheduled over seven days a week and provided by a number of staff and volunteers. Hours were flexible but staff were employed in the week from seven a/m to seven p/m. In the individual unit there was a schedule of activities planned. These included: Poetry day, readings by staff and guests, quiz and word search, staff interaction, coffee morning, carpet bowls, exercise class, bingo, external singers, and head and hand massage. People spoken with had a copy of the schedule and were aware of activities taking place. We observed the activities person engaging with a group of eleven people throughout the morning, playing scrabble and completing a word search. A senior member of staff was going round to each person and encouraging them and when they started to lose interest they got a large ball and then in turn went to each person. There was lots of laughter and good interaction with people, staff and visitors which was inclusive. One of the activities coordinators told they did some fund raising and there was a raffle the following day. They said there were lots planned, including trips to town. People told us they were looking forwards to the weather getting better so they could take trips outside or stroll round the garden. The home employed a person who was qualified and able to give massage. Staff told us there was always something going on and people which ever floor were encouraged and supported to join in activities. However no organised events were happening in the lounge area in nursing unit, or the dementia nursing unit and after lunch everyone in the nursing unit in the main building was taken back to their rooms.

We did not see a large range of activity or activities which suited everyone's individual needs. For example we asked one person and they said, "Its word search today you need a good memory for that. " The person we were told had the onset of dementia. One relative told us there were not many one to one activities provided. We observed limited opportunity for people on Spiller unit upstairs to be meaningfully occupied. No activities were provided on the day of our inspection and staff told us that the activities co-ordinator only came to this unit on a Tuesday morning. When we asked about the activities co-ordinator one staff member said" We don't see them. On a Tuesday they do indoor bowls and puzzles. Staff are expected to provide activities but there is no time."
We asked if the service provided any specialist activities for people living with dementia or if there were any

dementia champions or people trained to be dementia friends but there were not. We did not see people engaged in anything other than sleeping or watching television.

The service was well set out and people had opportunities for socialising with other and separate areas where they could meet their family in private but we saw communal areas were not well used. There was information around the service about different planned activities, information about the service and meal choices.

We spoke with people about their experiences. One person told us, "The standards of housekeeping are very high, the nursing staff are very good and I have no problem with the quality of care. I would recommend the home." The service was homely and people commented on the high standards of cleanliness and there were no unpleasant smells.

We spoke with one person who was in bed by their choosing. Their health was being monitored as shown by records in their room. They had a daily journal which told us about their main needs. They said they were content. Their records showed they were drinking adequately for their needs and the staff were monitoring their skin to ensure it did not break down. They had a call bell in reach and access to drinks.

Another person was in their room and their relative told us they had a number of falls but said they were very active, and always on the move but said staff kept a close eye on them and always kept them informed about any changes to their health.

At the last inspection in August 2015 we found that care plans were difficult to follow and would not help staff unfamiliar with people's needs provide effective care in line with people's wishes. At this inspection we saw care plans had been updated monthly or when there was a change in a person's needs. Care plans were updated by the nurses following discussion with care staff, the person and next of kin. We asked how care staff knew about changes to people's needs and were told staff have access to care plans, room documentation and handover before each shift. One staff member told us, "We work a mixture of days and nights and this helps us with the care plans and helps us to inform relatives and helps us give more person centred care."

We looked at a number of care plans and although these documents were still substantial it was easier to find some essential information about people's main needs. Care plans covered care needs including moving and handling, evacuation in the event of a fire, nutrition, pressure care, continence, hygiene, skin integrity as well as their end of life care where appropriate. There was also some more personal information such as my choices, my preferences which told us more about the person and how they chose to have their care provided such as one person who liked to listen to Christian music. We found staff were aware of this person's particular preference and were able to talk to us about it. For example what would a good day/bad day look like and how staff should support them with all aspects of their care. Care plans had been signed by the person or their next of kin and this had been reviewed showing consultation was ongoing.

One care plan showed clearly how the service had responded to a person who was at significant risk of not eating/drinking enough for their needs. Staff were recording their food/fluid intake and also including how often they expected staff to promote fluids and whether the person had taken any or refused. There had been consultation with the dietician and GP. We noted that in this case the management of the person constipation could be improved on due to the lack of apparent actions taken when a person had not had their bowels open for seven days. They had previously been prescribed medicines to help with constipation. However this was not effective and had not been identified earlier by staff. This was brought to the managers attention.

The service had an established complaints procedure which recorded actions taken and had been signed off by the manager and regional manager. We saw complaints had been appropriately responded too in most instances but we could not always see the actions taken and the outcome. So we were not always assured that lessons were learnt or complaints were always satisfactorily resolved. For example for one person a safeguarding concern had not been raised by the service when it should have been and this had not been identified by the service through its audits or when the Regional team had signed of the complaint.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2015 we found some staff felt unsupported. Some people said they did not always experience a service which was responsive to their needs. At this inspection staff said they mostly felt well supported.

Staff said the manager and senior staff were visible on the floor and communication had improved. One relative told us, "The manager is often around 2 or 3 times a week and I often speak to her she is a really lovely person." The organisation had recognised some of the stresses faced by the staff team and staff were supported through unions. The organisation also had a confidential phone line staff could use to raise concerns if they felt they were unable to raise these internally. This helped staff have a voice and also for the organisation to analysis data about the service. In addition staff exit interviews were completed for the service to establish reasons why staff left and where possible to address areas of discontent. The service also had other systems of support for staff through observations of practice, regular team meetings with staff and one to one appraisals of their performance.

We asked staff about their support and one staff member said, "We are now having team meetings on the units once a month and any concerns can be brought up and if you do not speak up then nothing changes. Things are improving staff are more aware of person centred care for dementia and everyone has had dementia training." However not all staff felt able or confident to raise concerns.

Some staff had not received regular supervision. This was supported by records and it was clear that a number of recent changes had destabilised the service. We raised issues with the regional manager asking for feedback about some concerns raised with us

One relative expressed concern by saying they were concerned about how staff were meeting their family members needs due to a vast turnaround of staff and some who had no knowledge of their family member's condition. They said concerns had been addressed but they had to chase for information.

We found differential practices and levels of care on each unit and felt this was due to the ineffective deployment of staff and the availability of staffing particularly nursing staff. Without an effective, full management team it was difficult to see how this would improve to ensure consistency across the whole service.

We told the manager that comments about food had been once again an issue as it had been at previous inspections. The manager told us that food quality groups had been set up to consider this issue after some negative feedback from people using the service. This was held with the chef and people using the service. In addition the chef completed meal time audits, the last being in February 2016 which had raised a number of action points. There was an action plan in place with timescales and who was responsible. Remedial actions from a food hygiene visit had been met and the kitchen had been awarded 4 stars.

The manager said meetings with relatives and residents were organised and one was coming up. These were not held frequently. The last meeting was in October the next planned for April 2016. IPad were available in the service for people, relatives and visiting professionals to give their feedback at any time. The feedback was viewed by the manager and could generate actions which were seen and authorised by the Regional Manager. We saw a sample of minutes from meetings held including heads of department meetings and flash meetings which were held daily to identify any immediate concerns/ actions required.

We saw feedback both negative and positive and showed how the service was acting on feedback received. There were systems in place to ensure feedback was acted upon and where necessary investigations/actions were agreed and actioned.

The manager had a series of audits to complete and there was a team of internal auditors ensuring the service was being managed effectively. We saw some examples of monthly visits by the regional team. The report looked at compliance against agreed outcomes similar to the outcomes used by the CQC. Examples included, staffing, training safeguarding/complaints, staff/people feedback, infection control, medication, and nutrition. Action plans were developed from these audits. Areas of concerns had been around monitoring people health care needs where they might be at significant risk of unplanned weight loss, dehydration and skin integrity. The manager said they had a vulnerable residents list which was updated daily to enable them to respond to emerging/changing risk and this was communicated through handover and other staff meetings. The manager was also monitoring falls and rates of infection. Action plans showed how risk to individuals were identified, what was in place to manage the risk and if it was effective in reducing the risk. We looked at medication audits and through our own audit saw an improvement in this area.

Records were mostly well kept and all were made available to us promptly. We observed that there is a lot of recording for staff to do which took up considerable time; this included some information which was recorded in more than one place.

There were a number of initiatives at the service including a scheme which engaged volunteers to support people in the home through volunteering/befriending them. The service had nineteen volunteers. The Manager had attended a programme called My Home Life which was a group which helped managers to share good ideas, good practice with other health care staff/practioners to try and raise the quality of care they were providing to people.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs people's hydration and nutritional needs were not always being accurately recorded or taking into account people's menu preferences.

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 RA Regulations 2014 Staffing Staffing levels were not always adequate for the assessed needs of people using the service or take into account people's experiences of care. Regulation 18