Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Greenfield Residential and Nursing Home

Inspection report

Tag Lane
Ingol
Preston
Lancashire
PR2 7AB
Tel: 01772723745

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Ratings

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

Overall summary

The inspection took place on 11 & 13 March 2015 and was unannounced, this meant the provider did not know we would be visiting to inspect.

At the last inspection to this service on 11 September 2014, we found the provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were: Regulation 9 'Care and welfare of people who use services', because the registered person had not taken proper steps to meet people's social, personal relationships and emotional needs through the proper provision of personalised daytime activities; Regulation 23 'Supporting workers', because the registered person had not made suitable arrangements to ensure that all staff at the home were provided with appropriate

Summary of findings

supervision and appraisal; and Regulation 10 'Assessing and monitoring the quality of service provision', because appropriate measures were not in place to effectively manage the risks associated with the deployment of staff.

We found some improvements had been made with regard to provision of daytime activities, but more work was required for the provider to meet the requirements of this regulation. We found improvements had not been made with regard to supporting workers through supervision and appraisal and there were still significant concerns regarding staffing levels and staff deployment within the home.

Greenfield Residential and Nursing home is a large, purpose built property which is split into five areas to cater for people with differing needs. The home provides care and support for up to 112 people, whose needs range from personal care through to complex nursing care, including people who are living with dementia. There were 102 people using the service when we visited to inspect.

The home had a registered manager who had been in post since 20 June 2013. 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 we spoke with, and their relatives, told us they felt safe living in the home. However, we found that staffing levels were consistently below levels sufficient to provide safe care and treatment to meet people's needs.

Safe systems were in place for the receipt and disposal of medicines. Since our last inspection, we had been notified about a number of medicines errors, which had been made by bank staff and agency staff. We found guidance for the use of 'as and when required' medicines was inconsistent and peer checks on medicines, to quickly identify any mistakes were not being carried out.

We found the home to be generally clean and tidy. However, we witnessed some poor infection control practices, including empty soap dispensers in various areas of the home.

The service had implemented robust safe recruitment policies, which included obtaining references from previous employers and checks with the Disclosure and Barring Service, to help to ensure only suitable staff were employed.

People we spoke with, their relatives, staff and the local authority all raised concerns about how effective the service was. Relatives we spoke with gave examples of people not having received personal care, such as bathing or having their hair washed. They also gave examples of incidents where staff did not have the knowledge or skills to perform tasks, and where people had suffered as a result of inadequate monitoring of food and fluid intake and output.

Staff did not receive regular, worthwhile supervision and training, to ensure they had the skills and knowledge to carry out their role effectively.

People were at risk of receiving care or treatment that was unsafe or inappropriate because staff had not received specialised training in areas such as diabetes, dementia and stoma care.

During the inspection, we observed staff sought consent from people before they delivered care. However, we found that the registered person had not ensured that staff understood their responsibilities with regard to gaining consent from the people in their care with regard to the Mental Capacity Act 2005.

People we spoke with said the food was good and varied. As well as allotted mealtimes, we saw people could request drinks and snacks throughout the day. Staff did not always ensure the amount of food and drink people took was recorded. We witnessed inconsistencies with the support provided for people at mealtimes, including some poor practices when supporting people to eat their meals.

We saw from people's care records and people we spoke with confirmed they were able to see healthcare professionals when they required them. This included GPs, chiropodists and dentists.

People we spoke with and their relatives told us that staff were generally kind, considerate and caring. However,

Summary of findings

they also told us that due to the low staff numbers, pressures on staff to complete tasks meat that it was very difficult for them to build caring and positive relationships with people who lived at the home.

We found that the registered person had not ensured people were fully involved in reviewing their written plans of care to ensure people's preferences and wishes were taken into account.

We spent time in each area of the home to observe how staff interacted with people. We saw the staff approach to people was consistently good. We saw staff were friendly and caring towards people and responded to them sensitively. However, some staff approached situations dealing with people who were confused or agitated in a way that appeared to increase people's confusion.

We looked at whether people received personalised care that was responsive to their needs. Residents and relatives we spoke with, as well as information we received from the local authority, raised concerns that people were not receiving care that was centred on them. We found cases where people's personal care and social needs had been neglected.

Assessments of people's needs and care plans associated with them were regularly reviewed and updated. However, people or those important to them, where appropriate, were not regularly involved in reviewing the care delivered by the service. Records contained little or no information about people's wishes, preferences, life histories, strengths or aspirations.

Throughout the inspection, we observed examples of a very task-led culture at the home, where staff were under pressure to complete tasks, rather than to deliver personalised care to people.

Although improvements had been made with regard to activities, there was still some work to be done to ensure people were provided with activities that were meaningful to them.

People we spoke with and their relatives told us they knew how to make a complaint and were happy to do so. However, we received mixed responses as to the satisfaction of people who had raised concerns with management at the home.

Systems designed to assess, monitor and improve the quality of the service were not effective.

We found several breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010 in relation to staffing, management of medicines, cleanliness and infection control, supporting staff, care and welfare, gaining consent to care and treatment, nutrition, respecting and involving service users and assessing and monitoring the quality of service provision. These breaches equate to breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to staffing, safe care and treatment, meeting nutritional and hydration needs, person centred care, need for consent and good governance.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing levels in the home were not sufficient to ensure people received safe care and treatment that met their needs.

We observed some poor infection control practices which meant that people were not properly protected against the risks of the spread of infection.

There were safe systems in place for the ordering, receipt and disposal of medicines. However, guidance provided for staff with regard to the use of 'as and when required' medicines was inconsistent. Peer checks of medicine records, which were used to identify and address any issues, were not being completed.

Is the service effective?

Requires Improvement

The service was not effective.

We found staff were not receiving regular, worthwhile supervision to ensure they had the knowledge and skills to carry out their role effectively.

Staff received mandatory training during their induction and regular refresher courses. However, staff did not receive specialised training in areas such as diabetes or stoma care, which meant they may not be able to provide care to meet people's needs.

People may not receive adequate nutrition and hydration to meet their needs because systems to monitor people's food and fluid intake were not operated effectively. Support provided for people who needed help with eating and drinking was inconsistent.

Is the service caring?

Requires Improvement

The service was not caring.

Due to the low staff numbers, pressures on staff to complete tasks meant that it was very difficult for them to build caring and positive relationships with people who lived at the home. Staff were moved between areas of the home to cover for staff shortages. This meant that people were cared for by staff that did not know them well.

People's privacy and dignity was respected. People were able to choose where they spent their time. Personal care was delivered in a sensitive way, behind closed doors.

Interactions between staff and people they supported were task-led. In particular, where people chose to stay in their bedrooms or were being cared for in bed, interactions were very infrequent, which could lead to people feeling isolated.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive.

Due to the lack of involvement in the review and care planning process, people may not receive care that took into account their individual needs and preferences.

Improvements had been made with regard to activities provided for people. However, some work was still required to ensure that people had the opportunity to participate in meaningful activities.

A suitable complaints policy and procedure had been implemented by the provider. The registered manager had a good understanding of how complaints should be dealt with. However, people we spoke with gave us examples of where concerns had been raised with management without any noticeable improvement in the care delivered.

Is the service well-led?

Requires Improvement

The service was not well-led.

Regular audits and checks were carried out by the management which were designed to assess, monitor and improve the quality of the service provided. However, we found these systems were not effective in identifying and addressing the concerns highlighted in this report.

The culture at the home appeared very task oriented and staff morale was very low. There had been a high turnover of staff since our last inspection, including house managers and nurses. Staff we spoke with told us this was due to the pressure that the staff team was under and a lack of support from management.

Greenfield Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 11 & 13 March 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist professional advisor in the care of older people 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. The expert by experience had experience of caring for someone who used residential and nursing care.

Before the inspection, we gathered information from a variety of sources. This included notifications about significant events we had received from the provider. We also spoke with family members of people who used the service. We also spoke with the local authority commissioning and safeguarding teams and the local clinical commissioning group to gain a balanced overview of the experience of people who used the service.

During the inspection, we spoke with 14 people who lived at the home and eight relatives of people who used the service and we spoke with two people's relatives over the telephone, following the inspection. We also spoke with 19 members of staff, including the registered manager, clinical services manager and house managers.

We observed the care delivered and interactions between staff and people who used the service in all five areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a tool we use to gain insight into people's experiences when they are unable to communicate with us.

We looked in detail at the care records for five people and reviewed other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service and their relatives about whether they felt safe living at the home. People's comments included: "I feel very safe I have my door open and I can see and hear people talking and walking about"; "It's secure, there's always someone about"; and "I feel alright, I feel safe here". One relative told us: "Well, yes, I suppose so", when we asked whether their loved one was safe. This relative raised concerns about staffing levels in the home. Other relatives we spoke with also shared the same concerns. People and their relatives felt the staff helped to keep people safe, but that there simply were not enough staff on shift to ensure people received the care they needed, when they required it.

We reviewed staffing levels in all areas of the home. We found that in four areas out of five, staffing levels on the rota did not match the assessed requirements. We were told by the registered manager that where there were gaps in staffing, they used bank staff, regular staff and agency staff to cover these shifts. However, during our observations around the home, we found there were still gaps in staffing that had not been covered.

We spoke with staff in each area of the home about staffing levels. We were told by every member of staff that we spoke with that there were not consistently enough staff on duty to meet the needs of the people in their care. Staff told us they were often asked to cover additional shifts and felt under pressure to do so. We were also told that staff were regularly asked to cover shifts in areas of the home with which they were unfamiliar. During our inspection we spoke with some of these staff members. They explained that they did not know the people they were caring for and did not have time to read people's written files in order to gain an understanding of their needs. They instead relied upon other staff in that area of the home to relay important information to them. This meant that people who lived at the home did not receive care from people that knew them well and knew their needs and, as a result, there was an increased risk of people receiving inappropriate or unsafe care and treatment.

People we spoke with, their relatives and staff all gave us examples of where care, for example, bathing, washing hair, helping people to the toilet had suffered as a result of the staffing levels within the home. One person told us: "No, not enough staff. I can wait a very long time for someone to help me up"; another said, "There aren't enough staff and too many different staff I have never seen before". A relative told us: "I pop in at different times throughout the day, every day. Usually there are only two staff on. I can wait twenty minutes in the lounge and more to be let out of the building because I can't find a member of staff to work the key pad and let me out."

Staff were very pushed to carry out their responsibilities. Due to the pressure they were under. The culture in the service had become very task orientated, rather than person-centred. This meant people were seen as tasks that needed to be completed, rather than people who required care and support. A senior member of staff said: "We are very short staffed. There is a big turnover in staff. If we had more staff we would have more time to spend with the residents. Good staff leave because they are put under pressure."

In one area of the home, there had been several incidents where people who lived in the home had had altercations with each other. The provider recognised that they needed to increase observations of people who displayed behaviour which may challenge the service. However, we found that staffing levels were not increased adequately to ensure these observations took place consistently.

There had been a high turnover of staff within the last six months prior to the inspection. There were also a number of staffing vacancies, including a house manager, qualified nurses, care staff and a hostess. The provider was actively seeking to recruit people to these roles and a number of new care staff had been offered jobs and were due to commence employment immediately. However, we found staffing levels during our inspection were not adequate to ensure people's needs were met fully.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed at all times. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people's medicines were managed. People we spoke with told us they were satisfied with how the service managed their medicines. Relatives we spoke with did not raise any concerns regarding medicines.

We had received notifications from the provider and from the local authority that there had been a number of

medicines errors since our last inspection. The medicines errors that had occurred were made by bank staff and agency staff, who had been employed to cover shifts due to gaps in staffing levels. This led us to question what checks were carried out to ensure staff were competent and sufficiently knowledgeable to administer medicines. The registered manager confirmed that bank staff were trained to an appropriate level and that agency staff details were checked to ensure they were suitably qualified before they were allowed to administer medicines.

We observed a medicines round during our inspection and found that staff followed safe practices when dispensing and administering medicines for people. Medicines were stored appropriately in secure rooms around the home. We discussed medicines management with the Clinical Services Manager, who explained the systems and processes to us, in respect of ordering, receipt and disposal of medicines. We were able to see from records that these processes were followed in practice.

We looked at people's medicines administration records in two areas of the home. We found that there was inconsistency with regard to written protocols for staff about the use of 'as and when required' medicines. They were in place for some people, but not for others. This meant that some people, particularly those who were unable to ask for their medicines, may not have received them when they needed them.

We spoke with the nurse in charge of one of the areas of the home, who told us that they had systems in place to audit medicines. This included a peer check system for early identification of errors. We were told and records confirmed that this peer check was not being carried out. This meant that errors may have gone unnoticed until the next formal medicine audit, which was carried out monthly.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at all areas of the home and found it was generally clean and tidy. We found areas such as bathrooms and toilets had suitable wall and floor coverings which leant themselves to easy cleaning and disinfection. There was guidance available for staff on hand washing and staff had undergone training in infection control.

However, we did witness some poor infection control practices. For example, when we were carrying out observations over the lunchtime period, we noted that in one area of the home, staff did not wash their hands before proceeding to serve people with their meals. We also found practices such as storing linen on top of a commode in one of the bathrooms, coat hangers being left on grab rails and we found discarded gloves on the floor of one of the bathrooms. We also found that several of the soap dispensers around the home were empty of soap and that waste bins were broken and unable to be foot operated. This showed that staff were not following infection control procedures, in line with best practice and that the measures the provider had put in place to identify, prevent and control risks of infection were not being operated effectively.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's written plans of care and associated documentation, to see how information was recorded and presented for staff to help keep people safe. We found that assessments of people's needs were carried out prior to people moving into the home and were regularly reviewed and updated. Assessments of people's needs were used to inform people's written plans of care which gave staff guidance on how to meet people's care needs safely.

Environmental risk assessments were carried out and staff were aware of the requirement to report any hazards. People's bedrooms and communal areas appeared safe. The home was secured by keypad locks. No one we spoke with raised any concerns about the safety or security of the premises. Plans had been put in place to deal with foreseeable emergencies such as fire, flood or power loss. Each person who lived in the home had a personal evacuation plan, which was individual to them, in case they needed to be evacuated from the building during an emergency.

People and their relatives told us they felt safe with staff and had not witnessed anything that would give rise to concerns about people suffering discrimination or abuse. Safeguarding policies and procedures had been implemented by the provider and staff had access to contact details for reporting any concerns. Staff undertook

Inadequate

Is the service safe?

training in safeguarding adults during their induction and at set intervals as part of their mandatory refresher training. All the staff we spoke with were able to explain what it meant to keep people safe and how they would report anything that concerned them. Information and guidance about safeguarding and whistleblowing was readily available to staff. We had received a number of safeguarding concerns about this home since our last inspection. We found that the provider undertook investigations and made changes as a result of their findings, to try to ensure people's safety.

We found the service had implemented safe recruitment practices and disciplinary procedures. We found that the service carried out checks including obtaining references from previous employers and checks with the Disclosure and Barring Service (DBS) before staff were offered employment. These checks helped to ensure that only suitable staff were employed.

Requires Improvement

Is the service effective?

Our findings

People we spoke with, their relatives, staff and the local authority all raised concerns about how effective the service was. Relatives we spoke with gave examples of people not having received personal care, such as bathing or having their hair washed. They also gave examples of incidents where staff did not have the knowledge or skills to perform tasks, and where people had suffered as a result of inadequate monitoring of food and fluid intake and output.

Staff we spoke with confirmed they did not have regular supervision. Supervision sessions appeared to be used as a corrective and reactive measure when something had gone wrong, rather than being used proactively to ensure staff had the knowledge, skills and motivation to undertake their role effectively. Staff we spoke with also told us that they had not received copies of their annual appraisal.

We spoke with staff about the training they had received to enable them to undertake their role. We were told that staff undertook mandatory training, such as safeguarding, moving and handling and infection control, amongst other topics, as part of their induction programme and mandatory refresher training. This helped to give them the basic skills and knowledge they needed to care for people who lived at the home. However, staff told us there was very little additional training that took place.

From our observations, it was apparent that staff who were caring for people who were living with dementia and people who could exhibit behaviours which challenged the service, were underprepared for their role. As such, people may have not received effective care and treatment. For example, we observed staff interacting with people who seemed confused and agitated. One person was observed to occasionally shout for 'help'. We observed a staff member approach this person, they said "[Person], why are you asking for help?" In a different area of the home, we observed two people shouting and screaming. A staff member asked them why they were shouting and screaming. In each case these people did not understand why they were being asked this question, which led to further confusion.

This was in breach of Regulation 23 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, in one area of the home there were people who were living with diabetes. A member of staff that was working in that area of the home confirmed they had not received any specialist training to help them care for people who were diabetic. We were told by another person's relative that they had to show staff how to deliver stoma care, because staff had not had the training to do so. This meant that these people were not cared for by staff who had been trained to provide the specialist care and support they required in a safe manner.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager and staff. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We looked at how the service gained consent to care and treatment. We saw throughout our inspection that staff gained consent from people before they undertook any care tasks. We asked people and their relatives whether they were involved in the planning of care for themselves or their loved one. None of the people we spoke with could recall being involved in reviewing plans of care. When we looked at people's care documentation. We were unable to see from these records how often or how much people were involved in reviewing the care delivered to them. Only one out of the five records we looked at contained any

Is the service effective?

input from people's relatives, which was very brief. There was no record of discussions or meetings with this family member. Plans of care were regularly reviewed, however the reviews did not involve the person concerned.

We found care staff had limited knowledge around the MCA and DoLS. The registered nurses we spoke with were able to describe the main principals of the legislation, as was one carer, however the rest of the staff we spoke with were not confident regarding their responsibilities. Staff told us they had not received training on the MCA or DoLS. Training records showed and management confirmed that staff had received training on the MCA and DoLS, but there had been no checks made to ensure staff understood the training and could put it into practice. The policy in use in the home, relating to MCA and DoLS, had not been reviewed since 2012 and did not reflect recent high court rulings relating to DoLS.

We found that the registered person had not ensured that staff understood their responsibilities with regard to gaining consent from the people in their care with regard to the Mental Capacity Act 2005. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had applied for authorisation under DoLS where appropriate. Where authorisation had been granted, any conditions of the authorisation were adhered to. We did not witness any deprivation of peoples' liberty other than those which were authorised.

We looked at how people were supported to eat and drink enough to maintain a balanced diet. We observed the lunchtime period in four of the five areas of the home and ate lunch with people who lived there. People we spoke with said the food was good and varied. As well as allotted mealtimes, we saw people cold request drinks and snacks throughout the day.

In each of the areas we observed, we found staff were under a lot of pressure to meet the needs of the people they supported. We saw that where people required support to eat and drink, they received this from staff, but to varying degrees. For example, we witnessed one carer delivering very patient and respectful support to a person in one area, whilst they sat beside them and gave them their full attention. However, we also witnessed poor practice, where staff members were observed to continue conversations with colleagues whilst supporting people to eat.

Most people in each area of the home used the dining room at mealtimes, whilst others chose to eat in their bedrooms. The food we sampled was of good quality. However, we observed that food which was taken to people in their rooms could be left in a heated trolley for 30 minutes or more, in which case the temperature of the food was significantly decreased. This meant people who chose to eat in their rooms, or those that did not want to eat at allotted mealtimes, could be served food that was much cooler.

We observed some people who were not eating their meals being prompted by staff and offered alternatives. However, we saw two people who refused to eat were given little prompting or support by staff, which resulted in them not eating during the lunchtime period. The home employed a 'hostess' in three out of five areas of the home. The hostess was responsible for ensuring people had enough to eat and drink throughout the day and for recording how much people ate and drank. We observed staff members clearing people's plates of leftovers, without showing or telling the hostess how much people had eaten. This gave rise to concerns that the recording of people's dietary intake may have not been accurate.

We did not find any evidence of people suffering any significant weight loss during our inspection. However, we were told by a relative of one person that their loved one had been admitted to hospital in the previous months, due to dehydration. They explained that they now always have to check that food and fluid charts have been completed, as staff did not always complete them properly.

The matters above constitute a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were at risk of not receiving nutrition and hydration which met their needs.

We spoke with the person who was responsible for preparing meals. They explained that they were given information about people's dietary requirements when people first moved into the home. This included any

Requires Improvement

Is the service effective?

allergies, cultural needs and any special requirements, such as soft or pureed diets. This helped to ensure that people received a diet which met their individual needs. There was a choice of two main meals at lunchtime and for the evening meal. People were able to choose alternatives if they did not like what was on offer. On occasion the provider undertook a consultation with people who lived at the home, to make sure their food and drink preferences were taken into account with regard to menu planning.

We saw from people's care records and staff confirmed that people were able to access dietary and nutritional specialists if they needed to. These included dieticians and speech and language therapists. This helped to ensure staff had access to specialist guidance and advice regarding people's nutrition and hydration.

We saw from people's care records and people we spoke with confirmed they were able to see healthcare professionals when they required them. This included GPs, chiropodists and dentists. However, when we spoke with people's relatives, they raised concerns that, in some cases, the service delayed contacting GPs. We discussed this with the registered manager and the clinical services manager, who told us that they had recently had some problems with making referrals to a local GP practice. They had been undertaking work with the GP practice to improve the process and to improve the experience of people who lived at the home when they needed to see a GP.

Requires Improvement

Is the service caring?

Our findings

People we spoke with and their relatives told us that staff were generally kind, considerate and caring. However, they also told us that due to the low staff numbers, pressures on staff to complete tasks meant that it was very difficult for them to build caring and positive relationships with people who lived at the home.

Comments we received from people included; "The staff are lovely, there just aren't enough of them"; "The staff are very friendly and respectful"; "There have been some very good staff, but they have left" and "I love [staff], they always plump my pillows up when they come to turn me". Relatives we spoke with all told us that they thought the majority of staff were caring, but that they did not get enough time to spend with people who lived in the home.

We saw that staff were moved between areas of the home to cover for staff shortages. This meant that some staff supported people who they did not know very well. We spoke with one member of staff who explained they did not know the needs of the people they were supporting and had to ask colleagues for information. They told us that the information was in the person's care documentation, but they did not have time to read it. We observed the staff team to be very task oriented, with people seen as tasks that needed to be completed, rather than individual people who required support.

People we spoke with told us that they had been involved in planning their care when they first moved into the home, but could not recall having been involved in regular reviews of their care since. When we looked at people's written plans of care, we did not see evidence of people's regular involvement in reviewing their care. Where people were judged to lack capacity to make decisions around their care, we did not see evidence of regular involvement of people's relatives or any advocates in reviewing plans of care, other than the initial assessment and information gathering documentation. This meant that people's written plans of care may have not always reflected their current preferences.

We saw that, in the main, people's privacy and dignity was respected and their independence promoted. We saw that staff knocked on people's doors and asked whether it was alright to enter before they went into people's rooms. Personal care was delivered in a discreet way, behind closed doors. Nobody we spoke with raised any concerns about privacy or dignity. A lot of the people who lived in the residential part of the home were independent to varying degrees. We saw that this was promoted and encouraged. For example, where people required minimal support with dressing or personal care, this was provided and people were encouraged to do what they were able.

However, we were also told that this was not always the case. One person told us that on the first night they came to stay at the home, the staff put the bedrail up; even though the person told them they were able to use the toilet by themselves during the night. This person found this very distressing. This has since been resolved. We were also told by relatives of one person that their loved one had a special chair which assisted them to stand. We were told that the chair was not used by this person because staff did not know how to operate it. This showed, in both cases, that the service had not acted in accordance with the person's wishes. In addition, we overheard one member of staff say "I have left the feeds to the end". This showed that the service was task oriented, rather than considering people's individual needs. In one area of the home, we saw one person finish their dessert then proceed to lick the table mat of the person next to them. Two staff members walked past during this time and did not react to this.

We found that the registered person had not ensured people were fully involved in reviewing their written plans of care to ensure people's preferences and wishes were taken into account. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time in each area of the home to observe how staff interacted with people. We saw the staff approach to people was consistently good. We saw staff were friendly and caring towards people and responded to them sensitively. However, in one of the areas of the home where people who lived with dementia were being supported, we witnessed some staff approaching people who were confused or agitated in a way that increased their confusion.

Requires Improvement

Is the service caring?

Staff spoke with people politely and offered explanations and encouragement when they were assisting people. However, especially for people who chose to stay in their rooms or those who were being nursed in bed, interaction was very limited.

People's records were stored securely. Sensitive information could only be accessed by staff who had authority to do so. This helped to maintain confidentiality for people who lived at the home.

Requires Improvement

Is the service responsive?

Our findings

<Summary here>

We looked at whether people received personalised care that was responsive to their needs. Residents and relatives we spoke with, as well as information we received from the local authority, raised concerns that people were not receiving care that was centred on them.

For example, one person we spoke with, who was cared for in bed, told us; "I would love to have my hair washed once a week. It will be a month this Sunday since it's been washed". We asked a relative whether this person had mentioned this to the staff. They told us their relative had raised a concern three weeks previous but nothing had changed.

We asked a relative what they thought about the care delivered to their loved one. They told us; "It's a quick in and out. It's now 2:30pm and she has not had a wash or her hair combed".

When we last inspected the service in September 2014, we found that the provision of activities was not sufficient to meet people's social needs. The provider supplied us with an action plan telling us what they intended to do to meet the regulation. We spoke with people, their relatives and staff about how meaningful activities were provided for people and how people could remain involved in the community, if they wished to do so. We were told by everyone we spoke with that activities appeared to have improved since our last inspection.

During the inspection we saw some activities that were provided, which included arts and crafts, books, board games and films or television. The home had arranged for the local church to provide communion in the home for those people who wished to receive it. This was delivered in a very personal way. We also saw notices in each area of the home which showed what activities were scheduled for the week. However, the notices were hand written, hard to read and, in three areas of the home, out of date. We asked people and staff what activities were provided. We were given examples like physical armchair exercises, 'our favourite memories', gardening, nail painting and hairdressing. Staff explained that due to staffing levels, they were unable to take people out into the community at present.

This showed that although improvements had been made with regard to activities, there was still some work to be done to ensure people were provided with activities that were meaningful to them.

We spoke with a relative who expressed distress that their loved one's bowels were not being monitored, despite this being a known problem for them. The relative had asked for monitoring to take place and we found during the inspection that the person was suffering from constipation. The relative raised concerns that their loved one was only receiving infrequent showers and had not recently had their hair washed. The person's care record confirmed this. Concerns were also raised by the same person that their loved one was often left in bed throughout the day. This meant they had very little interaction with other people which had a detrimental impact on their mood.

We did, however, see some good examples of how the service responded to people's individual needs. For example, one person who lived at the home was only able to speak very little English and had specific cultural needs. We found the service supported this person and their family with their cultural needs. This included respecting the person's wishes with regard to how they wished to be cared for in their final days.

We asked people and their relatives how involved they were in planning and reviewing the care delivered to them. We were told that an initial assessment was carried out before people moved into the home, which was very thorough. However, following that people were not involved in reviewing their care and were not asked for their opinion of the care delivered to them.

We looked at people's care documentation which showed that assessments of people's needs and care plans associated with them were regularly reviewed and updated. However, people or those important to them, where appropriate, were not regularly involved in reviewing the care delivered by the service. Records contained little or no information about people's wishes, preferences, life histories, strengths or aspirations.

Throughout the inspection, we observed examples of a very task-led culture at the home, where staff were under pressure to complete tasks, rather than to deliver personalised care to people. Staff explained that this was due to time pressures, because of the gaps in staffing levels.

Requires Improvement

Is the service responsive?

The examples above show that the service was not responding to people's individual needs. People did not receive care in line with their wishes and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that new care documentation was in the early stages of being implemented and showed us an example of the paperwork. We were able to see that the new documentation placed greater emphasis on people's individual needs, preferences, wishes and life histories. We were told that people and those close to them, where appropriate, would be more involved in the information gathering process and in reviewing care. Once implemented fully, this should address some of the issues around people's involvement in decisions about their care.

The provider had implemented a suitable complaints policy and procedure which was made available to each person who used the service and their relatives. We spoke with the registered manager and the clinical services manager about how complaints were handled. They both had a good understanding of how complaints should be dealt with, in line with the provider's policy and procedure. We were shown examples of investigations into complaints prior to the inspection, during routine communications with the registered manager. These were thorough and resulted in actions which needed to be taken to improve the service. We saw that where possible, the actions identified during investigations were put into practice and followed through.

People we spoke with and their relatives told us they knew how to make a complaint and were happy to do so. However, we received mixed responses as to the satisfaction of people who had raised concerns with management at the home. For example, one person told us they had raised concerns about personal care, bathing and hair washing sometime before the inspection, but found they still had the same concerns at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in September 2014, we found the provider was not operating systems effectively with regard to assessing and monitoring the risks associated with the deployment of staff. We received an action plan from the provider which told us how they would make improvements to meet the requirements of the regulation. During this inspection, we found that staff deployment was still having a negative impact on people who used the service.

Regular audits and checks were carried out by the management, including visits by the regional manager, which were designed to assess, monitor and improve the quality of the service provided. These included checks on care plans, medicines, the environment and equipment, as well as monitoring accidents at the home, such as falls. We saw records of accidents and incidents, and safeguarding alerts that were reported to the local authority. Our records confirmed that the home reported any incidents to us, as was required.

However, we found that the systems used to assess and monitor the quality of the service appeared to be ineffective in identifying and addressing the issues highlighted in this report. These included infection control, people's involvement in care planning, staff knowledge and skills, and staff supervision.

This is in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels had been identified by the registered manager as an issue. The provider was undertaking a recruitment drive to try to fill staff vacancies and we were told there were a number of new staff due to start shortly after our inspection.

The culture at the home appeared very task oriented and staff morale was very low. There had been a high turnover of staff since our last inspection, including house managers and nurses. Staff we spoke with told us this was due to the pressure that the staff team was under and a lack of support from management. The registered manager gave us a list of reasons that staff had left the home, however they also confirmed that no exit interviews had been carried out to try to establish trends or themes in the reasons for staff leaving.

We received mixed comments from staff with regard to the support they received from management. Some staff told us the support they received from their house manager and the registered manager was adequate. Other staff members told us they did not feel supported by the management team. Staffing levels were the biggest issue for all the staff members we spoke with. They confirmed they had raised concerns with management but that things did not seem to change.

The service had a current statement of purpose. This is a document which outlines the vision, aims and objectives of the service. There were clear lines of responsibility and accountability. Staff morale in all but one area of the home was very low and staff expressed concerns about the support they received from management. Due to the high turnover of staff and house managers, causing instability within the staff team, leadership at the home had suffered.

The home had a registered manager in post. The manager had registered with the Care Quality Commission in June 2013.

Most people we spoke with and their relatives knew who the manager was, although some people only knew who the manager of their area of the home was. People told us they were confident they could approach the management with any concerns and would be taken seriously.

We were told by staff and the registered manager that meetings had been set up as a forum for residents and relatives to discuss the service provided and any concerns. However, there had been a very poor attendance at these meetings and they were currently looking into other ways of gathering feedback from people who lived at the home and their relatives.

Staff meetings took place within each area of the home, where staff could raise concerns and make suggestions about how the service was run. However, due to the instability of management in some areas of the home, the meetings were inconsistent in frequency.

The registered manager held a daily meeting with the people in charge of each area of the home to discuss any

Requires Improvement

Is the service well-led?

concerns and to plan for the day. This helped to ensure that important items, such as hospital appointments or concerns about individual people could be addressed promptly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not ensured that staff understood their responsibilities with regard to gaining consent from the people in their care with regard to the Mental Capacity Act 2005.**

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 were at risk of not receiving nutrition and hydration which met their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not ensured people were fully involved in reviewing their written plans of care to ensure people's preferences and wishes were taken into account.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably skilled and knowledgeable staff were not deployed at all times. Staff were not supported by way of regular supervision.**

The enforcement action we took:
Where we have identified a breach of regulation during an inspection which is more serious, we will make sure action is taken. We will report on any action when it is completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems designed to assess, monitor and improve the quality of the service were not being operated effectively.**

The enforcement action we took:
Where we have identified a breach of regulation during inspection that is more serious, we will make sure action is taken. We will report on any action when it is completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Peer checks on medicines and guidance for staff on the use of 'as and when required' medicines were not sufficient. The provider had not ensured people were properly protected against the risks associated with the spread of infection. People were at risk of receiving care or treatment that was unsafe or inappropriate because staff had not received specialised training in areas including diabetes, dementia and stoma care.**

The enforcement action we took:
Where we have identified a breach of regulation during inspection that is more serious, we will make sure action is taken. We will report on any action when it is completed.