Monarch Consultants Limited

Parkside Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 6 and 7 April 2015.

Parkside Nursing Home provides accommodation for up to 50 older people with varying support needs including nursing and people living with dementia. On the day of our inspection there were 38 people living at the home.

Parkside Nursing Home required a registered manager. 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. At the time of our inspection a new manager had been appointed and had been in post since 1 April 2016. They told us and the operations manager confirmed that they had started the process to apply for the registered manager position. We will monitor this.

During our previous inspection on 8 and 9 April 2015 we identified two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how risks to people's needs were assessed, concerns about how people's medicines were managed and a lack of robust systems in place to effectively assess, monitor and improve the quality of the service. The provider sent us an action plan to tell us of what improvements they would take to meet these breaches in regulation.

At this inspection we found continued problems and a breach in these areas and additional concerns in relation to people's care records and documentation. Information available for staff that provided guidance of people's individual needs was variable in quality and content and in some instances no information was provided. People's daily records were not reviewed effectively to ensure people's needs were being met and action taken when changes occurred.

Risks to people had been assessed but the control measures identified to reduce harm had not always been in place, resulting in incidents occurring that were preventable.

Staff had received safeguarding adults training and were aware of their role and responsibilities. The provider worked with the local authority and investigated safeguarding concerns appropriately.

Some safety concerns were identified with the environment and people's personal evacuation plans were limited in detail about people's behavioural and anxiety needs.

Some improvements had been made to the management of medicines but further concerns were identified. Medicine trolleys were left unlocked when unattended; a person had experienced a delay in their eye drops being ordered. Two discrepancies were found when checking people's medicines that meant we could not be assured people had received their prescribed medicines.

Safe recruitment practices were in place to reduce the risks of unsuitable staff working at the service. Staffing levels were a concern to people and relatives. Three permanent nursing staff were being recruited and the provider had identified an additional deputy manager was required and this was also being appointed but these were not in place at the time of the inspection. Staff raised concerns about long working hours which may have been a contributing factor for staff absenteeism. This was being addressed by the provider. People's dependency needs were assessed and reviewed, concerns were identified about the deployment of staff.

Staff training opportunities had improved and support to staff including regular supervision and appraisal meetings to discuss their work and development needs, were improving.

Staff did not always gain consent from people before providing day to day support and before care and treatment. Where people lacked mental capacity to make specific decisions about their care and treatment, The Mental Capacity Act (2005) was adhered to. Where concerns had been identified about people's liberty and freedom the provider had taken action to ensure people were not unlawfully being restricted.

Some staff showed a caring and compassionate approach and were attentive to people's needs and used effective communication. Concerns were identified that not all staff treated people with dignity and respect and did not meet people's needs in a timely manner. The mealtime experience for people could have been better. Staff were frequently distracted and interrupted when supporting people with eating and drinking, affecting the quality and effectiveness of support provided.

People had information about advocacy information. The complaints procedure was being updated. People and their relatives received opportunities to attend meetings to discuss how the service was provided. However, relatives felt communication and the exchange of information and being informed of changes could be improved upon.

People had an assessment of their needs prior to moving to the service but information about people's needs, preferences, routines and social history was limited and variable. Activity coordinators provided activities over a seven day period.

Relatives and staff raised concerns about the changes with the management of the service and felt this had affected how the service was managed and provided. Staff were positive about the new manager and felt they were supportive and would be a good leader.

People and relatives received opportunities to feedback their experience about the service. The service and provider conducted checks and audits on the quality and safety of the service but these were not fully effective as they did not identify the issues we found during the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's health, safety and well-being were not always managed effectively.

People's medicines were not always managed safely.

Staff had attended safeguarding adults training and the provider took correct action when safeguarding concerns, incidents and allegations occurred.

Staffing levels were adequate when there was a full complement of staff on shift, however the deployment of staff could be improved upon.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received an induction and training opportunities had improved. Staff support and supervision was improving.

Where people lacked capacity to consent to their care and treatment, assessments and best interest decisions had been made appropriately. Where required, applications to the supervisory body to restrict people of their freedom and liberty had been made.

Staff's communication skills were variable. Consent before care and treatment was provided was not always sought from people.

People received sufficient to eat and drink and a choice of meals were provided. People did not always receive effective support with their eating and drinking.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were described and observations confirmed, some staff were kind, caring and compassionate. However, improvements

could be made about the approach of some staff.

People's privacy, dignity and respect were not always maintained. Staff interaction at times with people was more task-led than person centred.

Some people did not always feel fully involved or informed about their care and support.

People had access to independent advocacy information.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had a pre-assessment completed prior to moving to the service but care plans were variable in quality and there were gaps in some areas of care for some people.

Daily activities were available but some people felt stimulation and occupation needed to improve.

Complaints were recorded and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's systems for monitoring the service were not effective and did
not properly manage risk. Care records were not always monitored appropriately.

People, relatives and representatives received opportunities to share their experience of the service if they wished.

The provider was meeting their registration regulatory responsibilities.

Parkside 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.

This inspection took place on 6 and 7 April 2016 and was unannounced.

The inspection was conducted by two inspectors, a specialist advisor who was a registered nurse and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition to this, to help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted the local authority and clinical commissioning group who commissioned the service and Nottinghamshire Heathwatch for their feedback.

On the day of the inspection we spoke with three people who used the service and seven visiting relatives for their experience about the service provided. We also spoke with the manager, operations manager, regional manager, a deputy manager who was also a nurse, a night nurse, the cook, kitchen manager, two activity coordinators, three care staff and a care coordinator. We also spoke with a visiting nurse practitioner.

We looked at all or parts of the care records and other relevant records of six people who used the service, as well as a range of records relating to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 8 and 9 April 2015 we identified a breach of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. Concerns were identified about how risks to people were assessed and managed and the safe management of medicines.

We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that there were continuing problems with how people's risks and medicines were managed.

Two relatives talked to us about some concerns with regard to safe moving and handling of their family member. One relative said, "At the moment, they [staff] lift [family member] under their armpits to put them in and out the chair. Her skin is so fragile nowadays."

We observed staff follow good practice guidance when using a hoist to support people with transfers. However, we observed poor staff practice when supporting people to mobilise from a chair to standing. For example, wheelchair brakes were not always put on when a person was transferring. Staff were seen to use incorrect practice such as supporting people under their arms. This could cause a risk to people's health and safety.

We looked at the staff training matrix which showed that following our previous inspection staff had received refresher training in moving and handling. The manager told us that they had witnessed inappropriate moving and handling practice and had raised this with staff. They said further training in moving and handling had been arranged for staff in April 2016 and records confirmed this.

Two relatives told us about incidents that occurred where their family member had received an injury. The provider had investigated the incidents, taken action to reduce further incidents from reoccurring and met with the families of these people. However, both incidents were avoidable. For example, both people had been assessed as requiring either bed rail protection or a sensor alarm to alert staff when they had got out of bed. On the day of the incidents the sensor alarm was not switched on and rail protection was not in place.

We looked at accidents and incident records. We saw that in March 2016 a suction machine that was required to support a person with breathing difficulties was not in working order. This resulted in the emergency services being called to provide assistance. Whilst the provider had replaced this equipment this was an avoidable incident. An additional incident dated February 2016 detailed how a person had fallen out of bed. A floor mat that had been identified as being required to protect the person should they fall was not in place. This further demonstrates that avoidable risks were not managed appropriately.

Individual risk assessments had been completed to assess people's risk such as falls, developing pressure ulcers, nutritional risk, and moving and handling. These contained some information about how the person was affected and the control measures to reduce the risk. However, we saw a person who had fallen on several occasions had been reviewed by an occupational therapist who had prescribed a helmet for the

person to wear. Whilst we saw this person was wearing their helmet, the falls prevention plan was basic and did not refer to specific issues identified from investigations into the previous falls. This told us that staff, in particular new staff, may have not been fully informed of the action to keep this person safe.

We asked people and visiting relatives about how medicines were administered. One person said, "I get it at 9am every day and they [staff] give me a drink." A relative raised some concerns about their family member's medicine that had to be administered at a particular time. They told us, "[Family member] is supposed to have their next lot at lunchtime but they [staff] still haven't been yet and it's 1pm." Another relative was concerned that eye drops their family member took daily had been used before the next prescription had been received. We spoke with the deputy manager about this, they showed us records that confirmed the eye drops had been ordered and were waiting for delivery. However, they acknowledged that the need to reorder before the repeat prescription was due should have been recognised and actioned sooner.

We observed medicines administration and found medicines were administered by checking against the medicines administration record and staff stayed with people until they had taken their medicines. However, two medicines trolleys were closed but not locked when left unattended. This increased the risk of unauthorised access to medicines.

Since our last inspection an electronic medicines management system had been introduced and the medicines administration record (MAR) within this contained all relevant information. We looked at five people's MAR's in detail. We checked the medicine stock with the deputy manager and identified three discrepancies where tablets did not tally with the records. After further checks it was established that one discrepancy was a recording error and the person had received the correct medicine. There was a second recording error, and due to discrepancies in the amount remaining of this medicine and another medicine for the same person we could not be assured people were receiving their medicines as prescribed. We asked the manager to ensure a stock check was made of all medicines for all the people using the service to identify whether there were any other discrepancies. This was completed on both days of the inspection and no other discrepancies were identified. The management team told us they would implement a stock check of all medicines on a daily basis at the point of administration.

We saw the MAR for one person indicated they were given their medicines covertly. This usually involves disguising medicine by administering it in food and drink. As a result, the person is unknowingly taking their medicine. The deputy manager told us there were three people that had their medicine covertly. We checked their care records and found there was a mental capacity assessment and best interest decision for this. However, there was no evidence of the agreement of the GP for two people. We were told this had been given but the records to confirm this could not be located. There was no evidence to show the involvement of a pharmacist to ensure the effectiveness of the medicines were not compromised when administering covertly.

Protocols to provide additional information for staff about medicines which were prescribed to be given only as required, were not always in place. Those present did not always provide the necessary level of detail for staff about when the medicines were required. It is particularly important to provide clear directions for staff about when these medicines should be given in order to avoid over use.

Medicines were stored within a locked room. Processes were in place for the ordering and supply of medicines. Staff told us they had completed refresher training in medicines administration when the service moved to the electronic system and their competency had been assessed. Records viewed confirmed this.

Personal evacuation plans were in place in people's care records; this information was used to inform staff

of what people's support needs were in case of an emergency. We identified that this information was limited in detail, for example many people were living with dementia and information did not reflect people's behavioural and anxiety support needs.

We identified some concerns with the environment. For example a cupboard to store cleaning materials and another that had exposed heating pipes was found to be unlocked. We informed the management team who agreed to take immediate action.

People told use that they felt safe from the risk of abuse. A person who used the service told us, "I feel safe so far." Two visiting relatives told us that they had no concerns about safety. One relative told us, "I do feel [family member] is safe, else I'd be in more often." Another relative said, "Yes, we're happy [family member] is safe. I was impressed."

Staff were aware of the signs of abuse and told us they would report any concerns to their immediate senior on duty and would escalate through the management structure if necessary. One staff member said, "I know the people I work with and staff are never nasty. We are always calm." Staff also showed an understanding of the external agencies to contact to report safeguarding concerns, such as the CQC, the local authority responsible for investigating safeguarding incidents and the police. Information was available to staff about the local multi-agency safeguarding procedure for reporting safeguarding concerns and had attended safeguarding adults training. This information was on display and available for staff, people and visitors.

People we spoke with told us that they were generally unhappy with the level of staffing and availability of someone to provide assistance when needed. One person told us, "They could do with a few more [staff]. It's bedtime that's the longest time to go back to my room. It seems a long wait." A relative said, "It varies, they get short staffed and changeover is the worst time. We have to chase round to find someone."

Some relatives told us that their family member had or was receiving additional one to one staff support due to risks around safety. The manager told us who was in receipt of additional staff one to one and we saw this was provided as described to us. Staff also confirmed that people assessed as requiring additional support had their needs met.

Staff told us that staffing levels were sometimes affected by staff sickness. Whilst the provider used agency staff to cover sickness and vacancies, staff said that a problem arose when staff called in sick at short notice. They also said that if all staff were present and there were no shortfalls on the roster, staffing levels were sufficient in meeting people's needs and safety. One staff said, "The care is brilliant when we are fully staffed."

The management team told us that staffing levels were based on people's dependency needs and were regularly reviewed to ensure staffing levels were correct. Senior managers said that they were aware that staffing levels had been a concern for relatives and staff and that this had been discussed with them. We saw records that confirmed this.

On the first day of our inspection an agency nurse had not arrived as planned but action was taken to get this covered. We found staff were very busy and had limited time to spend with people and meal times were chaotic. The second day was calmer, more relaxed and better organised, suggesting there was an issue more with the deployment of staff rather than insufficient staff available. The management team agreed with our observations and said this was an area they had identified that required reviewing.

Safe staff recruitment and selection processes were in place. Records viewed confirmed the recruitment

process ensured all the required checks such as criminal records, employment history and identity were completed before staff began work. We also checked records that confirmed nursing staff's registration was up to date with the nursing and midwifery council. This was to ensure nurses were appropriately registered to practice.

Requires Improvement

Is the service effective?

Our findings

People's response to how effectively staff met their needs was varied; comments indicated that people's experience of effective care could have been better. One relative told us, "A lot [staff] are really good and most seem ok but some could do with more training in general care." Another relative said, "It's not always good. [Family member] has been bed washed today but wasn't finished dressing, they're still in their vest now and I had to find their shirt." An additional relative said, "I think they're [staff] capable, occasionally odd ones could do with dementia training."

Staff told us about the induction when they commenced work and said that this included shadowing more experienced staff before they provided care independently. Staff told us that they felt the induction helped prepare them for their role and responsibilities. One member of staff told us about the Care Certificate that they were still to complete. This is a recognised workforce development body for adult social care in England. This told us that staff received a detailed induction programme that promoted good practice and was supportive to staff.

Staff told us they had received training and all said that the training had improved since our last inspection. One staff member said, "The training is tip top." A nurse told us, "We are lucky here we get emails about courses and guidance." Staff told us they were reminded when their mandatory training was due. They said they felt they received sufficient training to enable them to provide effective care and treatment. We asked staff about some people's health conditions and found them to be knowledgeable.

We looked at the staff training matrix and training plan for 2016 and saw evidence that staff had received training and refresher training was planned and booked in advance. Training opportunities included continence and catheter care, pressure sore care, infection control, end of life care and dementia awareness. This supported staff to keep their knowledge and skills up to date with latest best practice guidance.

We asked staff if they had opportunities to meet face to face with their line manager to discuss their work, training and development needs. Staff told us that this support had been infrequent but felt better supported with the current manager. One staff member said, "I have had some meetings but not regular. The new manager is very supportive and approachable." The deputy manager told us that clinical supervision for nursing staff had improved. We saw a copy of the supervision schedule for 2016 that showed planned meetings dates with staff had been identified.

Staff told us that communication had improved since our last inspection and that staff handover meetings were better organised and structured. This included both written and verbal exchange of information. We observed a staff handover where each person's needs were discussed, this enabled staff coming on duty to be aware of people's health and well-being needs.

We observed staff were clear about their roles and responsibilities but communication between staff could have been better at times. For example, lunchtime observations in both dining areas on the first day of the

inspection was disorganised and chaotic at times.

Our observations of staff gaining consent from people either verbally or by other means of communication before care and treatment was provided was limited. We noted that staff carried out support more from habit with a brief explanation to the person whilst starting to support them, rather than asking first and then providing the support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Consent for the use of photographs in the care record, and for treatment and care had been recorded. Some people lacked mental capacity to consent to specific decisions about their care and treatment. We found mental capacity assessments had been completed and a record of the best interest decision had been recorded in accordance with this legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). When restrictions were being imposed on people in order to keep them safe, DoLS applications had been made to the Local Authority.

Some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. This is important information to advise staff of the person's end of life wishes or the best interest decision made on behalf a person who lacked mental capacity to make this decision. One person's DNACPR order indicated they did not have capacity to make the decision themselves. An Independent Mental Capacity Advocate (IMCA) had been involved as they did not have any family who could be consulted.

People who used the service and visiting relatives on the whole spoke positively about the food choices available. One person told us, "It's very good. They [staff] make a very good scotch broth." A visiting relative said, "It's good food and a lot of variety." Another relative added, "[Family member] is a vegetarian but the menu choice is a bit limited for that."

Staff we spoke with showed a good understanding of people's nutritional needs and preferences. Specific dietary and nutritional needs in relation to people's healthcare needs or cultural or religious needs were assessed and included in people's plans of care. These needs were known by staff including kitchen staff. We found food stocks were appropriate for people's individual needs. Where people had been prescribed food supplements these were available and records confirmed people had received these.

Most people required support from staff to eat and drink, whilst this was provided, the quality of the support, such as staff giving people their undivided attention, was poor at times. Staff were easily distracted by either having to support other people, or by other staff talking to them and this impacted on how effective staff support was. Some people used adapted cutlery and utensils to support them to eat independently.

Nutritional risk assessments and care plans were in place to ensure people received appropriate food and drink to meet their needs. Food and fluid intake charts were in place and people's intake recorded and weights taken. These were then monitored to enable action to be taken if required such as contacting

healthcare professionals for advice. Records of one person's last three monthly weight records showed that they had lost 6.2kg. We spoke with a care coordinator who said that they thought the weight record was incorrect as the person did not appear to have lost this amount of weight. They reweighed this person and there was still confusion about the person's weight but a referral to the dietician was made. This told us that the systems in place to monitor people's health needs were not always effective.

A person's nutrition care plan did not indicate they were receiving nutritional supplements. This person had lost 9kg in weight in five months and had been referred to a dietician. The dietician had advised the person should continue with these supplements five times a day. When we talked with staff they told us the person was being given the supplements but did not always drink them. It was not clear what further action had been taken to support this person's nutritional needs.

Feedback from relatives about how well their family member's health care needs were met on the whole was positive. One relative said, "The doctor has been a few times and the office tell us. [Family member] had their eyes tested here and had their feet done last week." However, one negative comment was made by another relative they said, "I wasn't happy. They [staff] didn't notice that [family member's] glasses were digging in on their nose and getting sore. It took me to do something about it and get the optician in."

Feedback from a visiting nurse practitioner that visited the service weekly was positive. They said that staff made timely health care referrals when concerns were identified. They added that any recommendations made were acted upon and that the nurses were knowledgeable and always able to answer any health related questions.

Care records confirmed people had access to a range of professionals including a dietician, optician, advanced nurse practitioner, GP, Parkinson's nurse and a speech and language therapist.

Requires Improvement

Is the service caring?

Our findings

People who used the service and visiting relatives on the whole were positive about the approach of staff and felt they were compassionate. Two people we spoke with told us they liked the staff and described them as caring, whilst one person said staff were kind most of the time. Two visiting relatives said they felt most staff were caring. Three relatives gave positive comments. One relative said, "The staff are lovely and very friendly. They definitely listen to my concerns about my wife." Another relative told us, "They [staff] do their best and do look after [family member]. If they are upset, they'll put an arm round and comfort them."

We saw examples that indicated staff had developed positive relationships with the people they supported. Staff demonstrated a good awareness and knowledge of people's needs and what was important to them and their preferences and routines. One staff member said, "We really do care for people, it's not easy work but I feel we all do our best to provide the best care we can."

Most people were living with dementia and experienced periods of anxiety. We saw how some staff used effective communication when talking with people. This included talking with people at the same eye level and using active listening skills. Staff picked up on people's anxieties and provided a calm, comforting and reassuring approach. However, staff did not always gain consent from people when providing care and support. For example, at lunchtime aprons were used for a number of people but we did not see any staff ask them if they would like to wear one and a reason provided. The apron was put on in silence or was being put on at the same time as saying, 'I'll just put this on for you."

We observed examples of how staff supported people's comfort needs and were concerned about their well-being. For example, a member of staff noticed a person's slipper had come off and asked the person if they would like them to put it back on which they did. A person was being assisted to move using a hoist and they were very anxious. Staff gave them lots of encouragement and reassurance during the process.

We also observed where the interaction of some staff could have been better. Often we saw staff start to support a person with their eating and drinking but then got interrupted or distracted. This resulted in them leaving the person before they had fully supported them without any explanation given to the person. For example, a person was supported by a member of staff that left them on three occasions to assist another person with no explanation given. Another staff member was seen to put an apron on a person at breakfast whilst they were asleep. We observed some staff support people at meal times with no interaction and communicated very little with them. Meal times were observed to be chaotic and disorganised. It did not reflect the provider's supported mealtime protocol that clearly set out the care, attention and support people should be provided with. Mealtimes did not provide a stimulating or enjoyable lunchtime experience for people. This told us that staff interaction was at times more task-led than staff providing a personalised service.

A further example of concern identified was how long people had to wait to be supported to go to the toilet. We observed a person ask to go to the toilet and was told by a staff member that they would be with them in a while, and to have their breakfast while they were waiting. This person was left for twenty five minutes.

They asked a passing member of staff if they could go to the toilet again. The staff member replied, "Yes [name of person]" and carried on walking past. The person looked across at us and it was apparent they were getting distressed. We went to alert another member of staff who said they would come as soon as the hoist was free. The hoist was brought across five minutes later.
We observed the activity coordinators talking with people and reminiscing about pastimes. Some people responded positively and joined in and other people smiled indicating their enjoyment of the company and contact. We observed a conversation with a person about the afternoon ballroom dancing. This was a stimulating exchange about where the person used to go to dance and what they liked to do.

Feedback from relatives with regard to their family member and themselves being involved in the development of people's care plans about preferences, routines and needs were mixed. One relative said, "I've just had a review meeting. And the girls [staff] will show me [family member's] chart if I ask about their weight or how many checks they do each day." Another relative told us, "I've only had a review with the service that funds the placement."

A member of staff said, "We like to involve residents and their family and invite them to their monthly care plan reviews." The deputy manager said they had done sixteen or or seventeen reviews with families in October and November 2015. From the sample of people's care records we viewed, we saw examples where people and their relative or representative had been involved in discussions and decisions about the care and treatment provided.

We saw people had access to information on how to access independent advocacy services. Advocacy services act to speak up on behalf of a person, who may need support to make their views and wishes known. There was historical evidence of the involvement of an independent mental capacity advocate that had supported a person who had no relatives or representatives to support them with their care and treatment decisions. However, there was no evidence of recent involvement. This meant that there was a risk that this person's best interest had not always been fully considered.

Relatives told us they were happy that dignity was respected and privacy maintained. One relative said, "Definitely they [staff] knock at the room and always shut the curtains when helping." Another relative said, "Oh yes, they are good with privacy. I leave the room."

We observed a member of staff administering someone's insulin injection in the abdomen whilst they were sitting in the lounge with other people. We did not hear the staff offering to accompany the person to somewhere more private to do this and they did not screen the person from other people's view.

Staff gave examples of how they provided privacy, dignity and respect when supporting people. One staff member said, "When providing personal care I close the curtains, encourage the person to do what they can for themselves and respect people's dignity by keeping the person covered up as much as possible."

Relatives told us there was no restriction on them visiting their family member. One relative told us, "I can come any time and am made welcome. I come twice a day usually." We observed relatives visiting over the course of the inspection and some told us they visited daily or stayed for long periods to be with their family member and supported their care and stimulation.

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with told us they felt that staff knew their family member's needs and routines. One relative said, "Yes, I think they [staff] know them and their routine." We asked if people felt their independence was taken into account. One person told us, "I have to wait for them [staff] mornings and evenings. They choose my clothes the night before and lay them out." A relative told us, "I'm not sure [family member] can do what she wants but it's unlikely." Another relative said, "They can't express themself now so relies on staff."

From the sample of care records we found an assessment of people's needs had been completed prior to people living at the service. One staff member told us that they were concerned that pre admission assessments were not always sufficiently detailed and people's admission to the home was not always well managed and prepared for. A visiting social care professional told us that whilst an assessment of a person's needs had been completed, care plans had not been developed to advise staff of how to meet their needs.

From viewing care records we found 'All about me' documents contained information about people's life history, routines and preferences. This information is important for staff to enable them to provide a responsive and personalised service. However, we found from six people's care records there was variability in the quality and content of this information and this information was missing in some.

Staff told us how people's religious and cultural needs were met. They gave examples where people received monthly opportunities to participate in visiting religious activities such as Holy Communion and prayers.

The care records we reviewed contained a range of care plans that advised staff of people's needs and how to provide this, although the amount of information in them was variable and did not always fully reflect people's needs. Personalised information lacked detail or was not present. For example, a person's personal hygiene care plan did not provide any detailed information on the support they required or information about their preferences.

Daily records for people's food and fluid intake and repositioning when there were concerns about people's skin were not always fully recorded. Staff told us that the nursing and care coordinators were responsible for these daily checks. We could not be assured that these were happening. We raised this with the management team who agreed there were concerns that checks on these records were not routinely completed. They told us of the action they had taken to address this which included care coordinators having further training on their role and responsibility.

Three people had a urinary catheter which was being managed by the community nurse. One care plan for the care of the catheter was detailed, another had very limited information and one person did not have a care plan in place. Staff we spoke with told us that they had attended training in catheter care and were knowledgeable about how to provide appropriate care. The manager gave us a copy of the provider's catheter care protocol. However, this was not found in people's care records we looked at and it was not

clear how staff had access to this information. The lack of specific written detailed information about people's individual needs may have impacted on their health and well-being.

Two people were described as being at end of life. One person had an appropriate and detailed end of life care plan whilst the other person did not. We discussed this with the deputy manager and care coordinator who agreed to complete these care plans as a priority.

A care plan for a person to 'reduce their agitation' provided useful information for staff on the triggers which could lead the person to become agitated. However, the guidance for staff in managing this was to 'engage in purposeful activities'. There was no information about the activities most likely to engage the person when they started to become agitated. Another person's care plan gave a little more information in that it said, 'Allow a safe environment to pace up and down' but again suggested the use of 'diversional therapy to diffuse the situation' but no details for staff were provided. Staff gave examples of individual people using the service and the ways they supported them to be calm when their anxiety had increased. The lack of written guidance for staff told us that they did not have all the information required to provide responsive and personalised care.

However, some care plans were detailed and informative. For example a person who had epilepsy had a seizure plan that provided staff with the required information to support them. The care plan for someone who did not speak English had some history about the person's language issues and provided guidance on how to communicate with the person. We saw examples where information about specific health conditions was provided at the front of people's care records to support staff with their knowledge and understanding.

We asked people about how they were supported with activities, interests and hobbies. Whilst we received some positive comments people also said they felt activities could be improved. One person told us, "People do singing. I get bored if no-one is around to talk to me." A relative said, "Activities are so important and I wish there was more for [family member] to do really. They'd like crafts, music movement type of exercise, some games and things like that." A relative of a person who was relatively new to the service told us, "I've not seen activities so far. I'd like to see more done in the lounge."

We spoke with two activity coordinators who provided activities over a seven day period. Both were found to be positive and enthusiastic about their role. We saw that a weekly activity timetable was on display to advise people of the activities available. We saw the activities that were provided during the two days of our inspection matched what was on the timetable. This included external dancers on one day and sensory baking on another. The activity coordinators told us how they also provided one to one time with people in addition to the structured activities. This included spending time with people who remained in their rooms. We saw records that clearly documented activities people had participated in. Both staff however said that they were often called upon to support the care staff and this impacted on them providing activities at times.

We observed in the ground floor lounge a radio was playing through the television until the afternoon dancing. A radio was put on in the dining area during a morning box game session with the activity coordinator. On the first floor, the television was on continually, with an afternoon film channel on. We saw no evidence of people being given a choice of what to watch or listen to.

Relatives told us that they were included in discussions and decisions about the care and support their family received. However, some concerns were raised about how well they were informed of any changes to their relative's needs. One relative told us, "We usually have to do the asking about why something has changed or how she is." Another relative said, "We do see the records and can look when we want. The

nurses will always answer us too." We saw that people's care records had been reviewed monthly. This was to monitor for any changes to people's needs.

Several relatives told us that they had made an official complaint. One relative told us, "Several times we've found [family member] not as they should be. They [staff] look into it and tell us what's been done. I asked for one particular staff not to be with [my family member] and they [staff] listened to me and they're not in with them now."

We looked at the complaints log and saw what action had been taken in response to the complaints received. However, we noted that not all complaints that we were aware of had been recorded but we knew action was being taken. We discussed this with the management team who agreed to update the complaints log.

There was not information available for people advising them how to make a complaint. The administrator told us that they were in the process of updating the complaints procedure and developing it into an appropriate format for people with communication needs.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 8 and 9 April 2015 we identified a breach of Regulation 17 HSCA (RA) Regulations 2014 Good governance. Systems and processes did not effectively assess, monitor and improve the quality of service.

We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that there was a continued breach with how the provider assessed, monitored and improved the service and how risks to people were monitored and mitigated. We identified new concerns relating to how records of people's care and treatment was completed, monitored and maintained.

We saw that regular audits had been completed this included daily, weekly and monthly checks that included infection control, health and safety, medicines and care records. The provider also had a process of completing regular audits in a variety of areas such as the environment, staffing, accidents and incidents, safeguarding and complaints. Action plans were developed to drive forward any areas that required further improvement. However, these audits and checks had not identified the concerns we found during our inspection. This told us that the providers systems and processes were not effective.

We identified concerns in relation to the quality and availability of information for staff to know how to meet people's needs effectively. For example, one person did not have a catheter care plan as required to inform staff of how to manage their needs. Another person had a catheter care plan but this lacked detailed information. A person who was described at end of life did not have an end of life care plan that advised staff of their wishes and how to support them with dignity and respect at the end of their life. A person who experienced periods of heightened anxiety had been prescribed medicines to take as required. A protocol was not in place to advise staff of how to use this medicine and no clear guidance regarding behavioural strategies were available. This told us the provider was not checking the effectiveness of care plans or had any way of assuring themselves that staff knew what to do.

People's safety and well-being had been assessed and risk plans were in place when incidents had occurred in relation to four people using the service, but the measures identified to reduce risks to people were not in place when the incidents occurred. These incidents were avoidable and caused people unnecessary harm, injury and distress.

Records were not always kept up to date and monitored effectively causing a delay in action being taken to support people's needs. We found examples where information was missing which may have impacted on people's health, safety and well-being. This included the ordering of medicines in a timely manner, people's weight being monitored and action taken when concerns were identified. We noted from one person's care records that they had been assessed by a speech and language therapist as requiring a soft diet due to risks associated with their swallowing. We reviewed the information available for kitchen staff with the cook and care coordinator and this information was not available.

During our previous inspection we identified concerns in relation to how staff were supporting people when

transferring from a chair to standing. At this inspection relatives raised concerns with how their family members were supported when transferring. We observed unsafe practice of staff and the manager told us this was an area that they had identified as poor. The provider had provided staff refresher training in 2015 and further training had been arranged in April 2016. However, the provider had not monitored the effectiveness of the training and assured themselves of people's competencies.

Relatives told us that the changes in management were a concern to them and they felt this had affected continuity and communication. One relative said, "The manager changes have been a real concern to us. We don't get introduced to the new one, so if we need anything we just ask the nurse or the office." Another relative told us, "It's not been a good situation. There's no continuity." Relatives were also frustrated that they had to ask for information instead of being kept informed. One relative said, "You have to ask to find things out. I just want them to be honest with us."

People that used the service and visiting relatives and staff all raised some concerns about the availability of staff and that agency nurses were used on a regular basis. The management team told us that they were in the process of recruiting three new permanent nurses which would reduce the use of agency nurses. An additional deputy manager was also to be recruited to further enhance the onsite management team. Some staff raised concerns with us about the shifts they worked and that they did not always get a break. We were concerned of the sustainability of staff working 14 hour shifts and not having breaks. This could impact on people's health, safety and well-being. A member of staff said they had real concerns about care staff getting to 'burn out' due to the hours worked. We raised this with the management team who were aware of some of these concerns. They told us that they had started a consultation exercise with staff and had a team meeting arranged in April 2016 to discuss these concerns further.

Staff told us that they had experienced a period of unsettlement due to the previous registered manager leaving and the service being managed by interim senior managers. They told us that they felt supported by the current manager and had confidence they would bring about positive changes.

We saw that all conditions of registration with the CQC were being met. The current manager of the service had been in post since 1 April 2016 and was in the process of submitting their registered manager application that we will monitor. They were clear about their role and responsibilities and some of the concerns we identified during the course of the inspection they had identified as areas of improvement. The manager said that they felt well supported by the senior management team within the organisation. The previous inspection ratings were displayed as required.

People and their relatives and representatives received opportunities to share their experience of the service via surveys and meetings. Relatives confirmed meetings were arranged. One relative said, "We've been to most of them, they're about every six to eight weeks. It's the same sort of things discussed like low staffing." Another relative told us, "The meetings are full of good intentions, but a change of manager doesn't help. Redecoration came up at one meeting and we're seeing the results now."

We spoke with the provider's quality assurance manager who told us regular surveys were sent to people who used the service, relatives, representatives, staff and professionals. Relatives told us that they had recently received a survey from the provider. One relative said, "We've just had a postal survey through funnily." Another relative told us, "We had a letter with a survey lately." The quality assurance manager said feedback would be analysed and an action plan developed where improvements were required.

We looked at a meeting record dated February 2016. We noted that the management team provided people with detailed and informative information on a variety of aspects of the service including areas of continued

improvement.

We looked at the provider's policy and procedure documents for safeguarding adults, The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and whistle blowing. We found that these documents gave an explanation of this legislation but not of the action staff should take should they need to use these policies. We discussed this with the management team.

We received concerns during our inspection that a lounge on the ground and upper floor were cold due to poor window insulation. Also concerns were raised about a person's bedroom. On the day of our inspection external contractors were replacing windows in both these areas and the provider had a refurbishment plan that had identified further environmental improvements

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must establish effective systems or processes to assess, monitor and improve the quality of service. The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of people use the service. The provider must maintain an accurate and complete record in respect of each person's care and treatment. Regulation 17 (2) (a) (b) (c)

The enforcement action we took:

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