Mr Barry Potton

Thornton Manor Nursing Home

Inspection report

Thornton Green Lane
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on the 28 and 29 July 2016 and was unannounced.

Thornton Manor nursing home is a private home that is set in its own grounds and located close to the rural village of Thornton –Le-Moors between Ellesmere Port and Chester. The service is based over two floors and is registered to provide nursing and personal care for up to forty seven people. At the time of our inspection there were forty four people living at the service.

There was a registered manager in post at the service since 2011. A registered manager is a person who has registered with the CQC 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 last inspection on 5 January 2016 we found that a number of improvements were needed at the service. These were in relation to the failure to assess and mitigate risks to people, poor management of infection control and cleanliness, a failure to ensure that people were always treated with dignity and respect and failing to ensure records were personalised. Following our inspection the registered provider wrote to us and informed us they would meet all the relevant legal requirements by the end of May 2016.

We also issued the registered provider and registered manager with a warning notice as records did not accurately reflect the care and support people required and quality assurance systems were not robust. We instructed both parties to meet all relevant legal requirements by 13 May 2016.

During our inspection we found that the registered provider had not demonstrated full compliance with the Health and Social care Act 2008 (regulated activities) 2014. We found that improvements had not been sustained and the registered provider was not meeting legal requirements. We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

People told us that they felt safe living at the service. Staff had an understanding of different types of abuse, how to safeguard people from abuse and how and who to report concerns too. However, areas we had previously raised relating to poor practice, institutional and restrictive practices had not been identified or addressed at the service. During our visit we asked a senior staff member to raise areas of concern we found to the local authority safeguarding team.

The service was not clean. Several areas across the building, including bathrooms were dirty. Equipment, fixtures and fittings were rusty, dirty or in need of repair, replacement or deep cleaning. Carpets and flooring in several areas of the home had an unpleasant smell or required replacing due to wear, tear and damage. Coats worn to access the kitchen for infection control reasons were dirty and stained. The management of

infection control was poor.

Sufficient checks were not made on pressure relieving equipment. Sixteen people used pressure relieving mattresses and we found that the settings for seven people were incorrect. One pressure mattress was unplugged from the power and this had not been identified by staff. Care plans did not evidence the correct pressure levels required for individuals. People were at an increased risk of developing pressure ulcers.

Risks to people's health and safety were not always identified. Where people had experienced significant weight loss or refused treatment for the management of diabetes staff had failed to access support and advice from relevant health professionals to minimise any further risks. Care plans failed to identify the specific equipment people required to support them with their mobility.

People received their medication as prescribed. People's medication administration records (MAR) had been appropriately signed when medication was given. Medication was stored in a safe and secure way. However, care plans for PRN (as required) medication were not in place for staff guidance. This meant that staff would not know when to give people their PRN medication, or at what dosage. This placed people at risk of having their medicine administered incorrectly.

Staff showed a basic understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered provider did not have a policy and procedure in place with regards to the MCA. Staff practice showed that consent was sought from people prior to care and support being provided. Care plans did not reflect how people's consent; ability to make specific decisions and decisions made in their best interests was considered. DoLS applications we reviewed completed by the registered manager had not considered the use of bedrails as a restrictive practice.

The mealtime experience varied across both floors. People who lived on the first floor were not able to sit at a dining room table to have their meal. The registered provider has confirmed that an additional dining room space has been introduced since we visited. Staff approach varied across the service. We found that staff on the first floor were task orientated in their approach and cultural practices and routines had been developed.

The service is advertised as a dementia specialist service. We found that the environment was not dementia friendly and no adaptions had been made to aid and support people who are living with dementia.

Records were not personalised and did not reflect people's individual preferences about how they would like their care and support to be provided. The registered provider had introduced supplementary records (day charts) which were used to record food and fluid intake and repositioning. We found that charts were not completed effectively by staff. There were gaps of up to 15 hours where no food, fluid or repositioning had been recorded. Information relating to what people had eaten and drank was not completed in detail to accurately reflect what they had consumed. This meant that the registered provider was not able to safely protect people from the risks of dehydration, inadequate nutrition and the development of pressure areas.

The quality assurance system in place was not effective and did not monitor the quality of care and facilities provided to people who used the service. We found continued issues as part of our inspection relating to the management of infection control and the overall condition of the environment. Audits completed by the registered manager had not identified or addressed concerns relating to the environment. Accidents and incidents were recorded on a monthly analysis, however there were no actions recorded to identify that the registered manager had considered risks, patterns or changes required to people's care needs. There were no actions identified to keep people safe from harm. Independent quality checks were not completed by the

registered provider.

The registered provider had failed to display the CQC report and ratings following our previous inspection at the service and on their website. These are required to be made available for public viewing by the registered provider.

People and their family members told us that they knew how to raise a complaint and felt confident that the staff and management would act upon them immediately. The registered provider had a complaints policy and procedure in place and records showed that complaints had been dealt with appropriately.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Risks and changes to people's health needs were not always identified and responded to in a timely manner. Advice was not always sought from relevant professionals.

People were placed at risk of developing pressure ulcers as insufficient checks were completed on pressure relieving equipment.

The service was not clean and Infection control was poorly managed, which placed people at risk of infection.

Medicines were stored and administered by suitably trained staff. However, care plans for PRN (as required) medication were not in place for staff guidance. This placed people at risk of having their medicine administered incorrectly.

Is the service effective?

Inadequate

The service was not consistently effective

Records and procedures did not always demonstrate that people's rights had been fully considered when implementing the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The environment was not dementia friendly. There were no adaptations or equipment in place to support people living with dementia.

Restrictive and cultural practices had not been recognised and addressed at the service.

The mealtime experience on the first floor required improvements to be made. People were limited in their choice as to where they would like to sit and with whom.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff were task orientated in their approach during our visit. Cultural practice and routines were in place throughout the day.

People on the first floor were not always presented with an opportunity to actively engage in social interactions with others.

Staff promoted choice with people and they told us that staff understood how they liked their care too be provided.

Is the service responsive?

Inadequate

The service was not responsive

Care plans were not personalised and specific to each person's needs and there was not always clear guidance for staff to follow when providing support.

Supplementary charts were not consistently completed. Insufficient detail was recorded as to what people had eaten and drank and the repositioning support they had received.

People knew how to raise concerns or make a complaint.

Is the service well-led?

Inadequate

The service was not well led

The registered manager and registered provider had failed to make the necessary improvements to the service following our last inspection visit.

Quality assurance systems in place were not effectively used. Systems did not always identify areas of concern or where improvements to changes were required.

The registered provider had failed to display their last inspection report and ratings for public viewing.

Thornton Manor 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.

We visited the service on the 28 and 29 July 2016. Our inspection was unannounced on the first day and the inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent us since the last inspection, complaints and safeguarding. We also contacted local commissioners of the service and the local authority safeguarding team to obtain their views. We were informed that there had been a recent change in senior staff at the service and some improvements had started to be progressed.

The registered manager had completed and sent us a Provider Information Return (PIR). The PIR is a document that asks the registered provider to give us some key information about the service, including what the service does well and any future improvements they plan to make to the service. We were unable to access and review this prior to our inspection.

As part of the inspection we spoke with seven of the people living in the service, five family members and eight staff including the director of nursing and quality and compliance lead. We also spent time with the registered manager and area manager. We observed staff supporting people and reviewed documents at the service. We looked at nine people's care records, medication records, training information and quality assurance processes in relation to the running of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us. We observed care and support in communal areas and staff interaction with people during a mealtime.

Inadequate

Is the service safe?

Our findings

People who lived at the service told us "It's been a treat being here, the way the staff treat people is wonderful. I know I will always be alright here". Relatives we spoke with informed us, "Sometimes they are short staffed and I think it would help if there were more staff, but I don't think people's safety is compromised" and "It's not grand here, but it's clean overall and [my relative] has their own space to walk about. They seem happy enough".

At the inspection in January 2016 we identified breaches of Regulation 12, 15 and 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014 as the provider did not have effective systems in place to identify and assess the risks to health and safety of people who used the service. In addition to this, we raised concerns regarding the management of infection prevention control. We issued the registered provider with requirement notices and a warning notice. On this inspection, we found the registered provider had made limited improvements.

We found continued issues in relation to the management of Infection prevention control (IPC) that required action. Since our previous visit we noted that the registered provider had replaced two bathroom floorings on the first floor of the service and also a number of windows across the building. However, we found that limited improvements had been made in relation to cleanliness of both the premises and equipment used by people. We found that carpets in communal areas across the service were stained and smelt musty. The carpet in the hallway on the first floor had started to gather on one side and formed a ridge of carpet which was a potential trip hazard. We were informed that the carpets at the service were going to be replaced with cushion flooring in the near future. We found that some bedrooms had a strong smell of urine and the carpets were stained. One bedroom we visited had a single square section cut out of the cushion flooring in the centre of the room which was a potential trip hazard. We spoke with a senior member of staff who advised us that the flooring had 'bubbled' and was due to be replaced.

Bathrooms on the first floor of the service were in need of repair and redecoration and equipment in the rooms was not always clean. Pedal bins in both bathrooms were broken and unable to be opened by foot. We found engrained stains and dirt around the plughole in one bathroom and we were informed by staff that this was the main bathroom used by people supported. Shelving units were rusty and radiator covers were visibly in need of replacement as the varnish had bubbled. In one bathroom we found that the shower chair was not clean and dirty used towels which had faeces on them were still in place in the bathroom. In the linen cupboard on the first floor we found that linen was being stored on the floor. This is in direct contravention of the guidance from the Department of Health Code of practice on the prevention and control of infections. This meant that people were at increased risk of infection.

The service had white overall coats in place for staff to use when entering the kitchen. These are used for infection control reasons. We saw that a number of the kitchen coats were heavily stained and dirty and we observed staff wearing these to enter the kitchen area during our visit. We spoke with a senior member of the team, the director of nursing and the quality and compliance lead for the registered provider who informed us that they would take immediate action to ensure that these kitchen coats were cleaned or

replaced.

The décor within the service was visibly in need of repair. There was damage to walls and paintwork and we observed heavily scuffed skirting boards across different areas. The service was at risk of harbouring bacteria due to the poor management of infection control.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not being protected against identifiable risks of acquiring an infection and the management of infection control was poor.

During this inspection we noted that some improvements had been made to individual risk assessments and management plans. Plans relating to pressure care, nutrition and hydration and risk of falls had been introduced where required and identified basic information about a person's individual needs.

The registered provider had ensured that, where assessed as required, people had an air mattress to minimise the risk of developing a pressure ulcer. We saw that a number of people were on pressure relieving mattresses but not all had an assessment to indicate what pressure setting was required. There was no evidence recorded to show that mattresses were regularly checked throughout the day to ensure they were working properly. This meant that people could be at further risk of developing skin problems if the settings were incorrect. We identified that pressure relieving mattresses for seven people were set at an incorrect level which did not correspond with their recorded weight. We noted that one person whose pressure mattress was set at 190kg instead of in line with their weight of 36.85kg had developed a pressure ulcer in July 2016. We requested that the registered provider raise this as a safeguarding concern to the local authority during our visit. One pressure mattress was disconnected from the power supply and this had not been noticed by staff who were sat with the person in their room at the time of this being discovered. A review of the person's notes regarding skin integrity was completed to ensure they had not come to any harm. We brought this to the attention of the clinical lead on the first day of the inspection and action was taken to ensure that all mattresses were set at the correct settings. This meant that people were at risk of not being protected from the risk of developing pressure ulcers.

In one person's care plan it was recorded that a pressure relieving cushion should be used for someone who was identified as a high risk of developing pressure ulcers. We saw that the person sat from 10.30am until 2pm at the upstairs dining table in their wheelchair with no pressure cushion in place. This meant that the person was placed at a high risk of further pressure areas developing. Staff had placed a pressure cushion under the persons feet, however there was no information recorded in the care plan to identify the reasons for why this practice was in place.

One person's care plan for diabetes stated that they required their blood to be monitored and tested (BM) on a regular basis. BM testing is essential to supporting necessary lifestyle and treatment choices and also to help monitor blood a person's glucose level. We found no records of BM testing having been completed. The person was supported to access a dietician and daily records outlined where a refusal to eat food recommended by the dietician had occurred. We spoke with the Registered Nurse on duty who confirmed that the person was non-compliant with a diabetic diet and therefore it was "pointless" to monitor their BM. There were no records in place that evidenced that advice had been sought from the GP with regards to the possible effects a refusal to comply with BM testing may lead to. We saw no risk assessment in place to identify and mitigate the risks associated with continued refusal. This meant the person was at risk of experiencing hypo or hyperglycaemic events due to unstable blood sugars. The local authority safeguarding team were contacted by CQC following our inspection visit to raise our concerns.

Where people were assessed as being at risk of weight loss, care plans identified what actions staff were required to take. This included monitoring of diet and fluid intake, changes in weight and where required an increase in high fat content food and fluids. However, records showed that a weight loss of 10kg since January 2016 had been recorded for one person and no action had been taken by staff. The monthly care home evaluation sheet dated 26 June 2016 recorded 'no ongoing concerns'. Nursing staff we spoke with confirmed that a referral to the dietician had not been completed. We raised this with a senior member of the team who made a referral to the dietician and to the local authority safeguarding team during our inspection visit.

Care plans did always not provide or reflect details of the correct equipment required to safely support people. Comments such as 'transfer with a full hoist' and 'ensure the correct sling is used' were recorded in care plans. Where changes in equipment had occurred, plans had not always been updated to ensure staff were provided with accurate information on how to safely support people. We found that bed rails were in place for 16 people who used the service. We reviewed the bed rail assessments for three people and found that these were generic and did not cover specific areas highlighted in line with the Medicines and Healthcare Products Regulatory Agency (MRHA) guidance on safe use of bed rails. Individual assessments were not personalised to identify the risk that the use of bed rails presented to each person. We found that the checklist for one person who had bed rails in place had not been completed. This meant people were at risk of receiving unsafe care and support that was not suited to meet their needs.

There was a protocol in place for the ordering, storage, administration and disposal of medicines. We looked at five people's medication administration records (MARS) and found they accurately reflected the medication given and medication remaining in stock. These included controlled drugs. Medication was also stored securely in a locked storage facility or the refrigerator.

A number of people using the service had PRN (as required) medication. The registered provider did not have care plans in place to direct nursing staff as to what situation these medications should be given, when and at what dose. There was no information recorded and readily available for staff to ensure people were given medication safely and consistently with regard to their individual needs and preferences. Failing to administer medicines safely places the health and wellbeing of people living in the home at risk of harm.

This was a repeated breach of regulation 12 and 17 of the health and social care act 2008 (regulated Activities) regulations 2014 as the provider did not have effective systems in place to assess, identify and take actions to prevent risks to the health and safety of people using the service.

Staff had an understanding of safeguarding and how to report any concerns they had about people. They told us that there was a poster in place in the nursing station which identified the contact details for the local authority safeguarding team. Staff were able to describe and identify what may constitute physical, financial, verbal and sexual abuse and what actions they would take if they witnessed this occurring. Records we looked at showed that staff had attended training about safeguarding vulnerable people. It was clear from observations during our visit that staff were aware of how to report concerns through to the local authority safeguarding team. However, areas we raised as part of our inspection relating to poor practice and restrictive practice had not been recognised and addressed. We have reported further on this under the effective domain.

Previously we found that the registered provider followed safe recruitment procedures. Recruitment records showed that appropriate checks including checks by the disclosure and barring service (DBS) were completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. This ensured staff were

suitable to work with vulnerable people. We were informed during our inspection that the service was operating short staffed due to short notice sickness. The registered provider had a process in place to deal with these situations occurring and a senior member of the team was contacted and attended the service for additional support. Following the actions taken, we observed that there were enough staff on duty during the inspection to meet people's needs and keep them safe

At the last inspection we saw certificates to show that there had been routine servicing and inspections carried out on items of equipment such as lifts, hoists and electrical and gas installation. Service contracts were in place so that these were renewed in line with safety and manufacturers guidance. Fire safety procedures had been regularly completed and records were up to date.

Inadequate

Is the service effective?

Our findings

People living at the service told us that if they didn't feel very well they could let the nurse know and they would ask the GP to come and visit them. Family members commented, "[My relative] has become more confused recently. They asked for the GP to come and visit them to make sure there wasn't any underlying illnesses". Staff confirmed and records showed that a variety of referrals had been made to the GP and/or other health professionals where concerns had been identified about a person health and well-being. An example of this had been where staff had noted a change in people's skin integrity and contacted the district nursing team for advice. However, we found that appropriate referrals had not always been made in relation to weight loss and the management of people's diabetes.

At the last inspection, we identified that improvements were required at the service In relation to the procedures, documentation and recording systems to ensure that the Mental Capacity Act 2005 was fully implemented. We issued a recommendation to the registered provider. We found that limited improvements had been made.

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. People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered provider had a policy and procedure in place to support the implementation of the principles of the MCA. However, we found that staff had a varied understanding and knowledge of MCA and DoLS. Inspectors were informed by staff that they thought this was to do with 'people's behaviours' or 'reporting aggressive behaviour' or 'choices of what to eat'. A senior nurse confirmed that training had been completed in April 2016 with a number of staff at the service. The registered provider shared the training matrix following our inspection which confirmed that 21 staff had attended this training. We raised concerns regarding the impact of the training and how we had not been able to evidence the staff learning into practice with the staff we spoke with. The senior nurse lead advised us they would review and revisit the training sessions with the staff team.

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. Capacity assessments had started to be used by the staff. Whilst there was evidence of some individual capacity assessments being completed these were very limited. There was no evidence of any 'decision specific' mental capacity assessments in regards to interventions such as the use of restrictive equipment such as bedrails. Other generic capacity assessments for 'activities of daily living' were in place in three people's files. Where people had been assessed as lacking capacity to make decisions, there was no evidence of best interest meetings having taken place. Care plans did not contain information relating to people's capacity to consent to care

and treatment.

We reviewed two DoLS applications which had been authorised by the local authority and found that details relating to the restrictive practice and use of bedrails were not highlighted by the registered manager as part of the application process. This meant that people were at risk of being restricted and/or restrained for the purpose of receiving care without lawful authority.

During our visit we found that 10 people had overlap tables placed directly in front of them in the upstairs lounge area. Comments made by the people included, 'I need to go to the toilet but I cannot move with this table stuck in front of me', we observed another person who became quite upset and said 'move this'. This meant that people's ability to move freely within the environment was restricted without help from care staff. We noted that overlap tables remained in front of 10 people from 9am in the morning until 1:30pm. Staff told us that they supported people to the toilet in the interim period. This confirmed that people required staff support to move freely. We raised this with the clinical director who immediately asked for them to be moved if people did not wish to have them in front of them. During our visit on the second day, we found that at 10:10am there were seven people with overlap trays placed in front of them in the upstairs lounge.

We noted that there was a large dining room table in the upstairs lounge/dining room. We saw that this table was used to restrict the freedom of movement of one person around the environment. We saw that another person supported in a wheelchair was placed at the end of the large table by staff and this resulted in the exit route being blocked for the person sat at the table. We had discussed these observations during our last visit with the registered manager, however changes had not been made. This demonstrated a poor culture/practice in the service which led to the potential restriction and freedom of people's movements.

This was a breach of regulation 13 and 17 of the health and social care act 2008 (Regulated Activities) Regulations 2014 as people movements were restricted in the environment and the registered provider had not recognised or addressed cultural restraint within the service. In addition the registered manager had failed to ensure that appropriate records regarding capacity and consent were in place in line with the Mental Capacity Act 2005.

We raised concerns during our last inspection regarding the mealtime experience on the first floor of the service. We issued a requirement notice for a breach of regulation 10 of the health and social care act (Regulated Activities) Regulations 2014. Whilst we found that some improvements had been made, further actions are required to be taken by the registered provider.

People on both floors were offered choices at mealtimes. Support was provided sensitively and staff gave people sufficient time to enjoy their food. However, the environment that people sat in on the first floor lounge/dining room was not conducive to a pleasant mealtime experience. We saw that there was not enough room for people to sit at the main dining table to eat their meal if they chose. The senior nurse confirmed during our visit that the registered provider had authorised another room to be turned into an additional dining room. This would allow people to sit together and enhance the social interaction with others during meal times. Following our inspection we received written confirmation that the additional dining room is now in use.

The registered provider identifies Thornton Manor nursing home as a dementia specialist service provision. During our inspection we found that the environment was not dementia friendly. There was no clear signage in place using both pictures and words to help and aid orientation of people living with dementia. We saw no evidence of any items of interaction or stimulus in the environment which could be used to support

reminiscence and way finding such as memory boxes, pictures of the local areas and favourite pastimes of people supported. There were no items of familiarity in place to support people living with dementia to understand what a room, cupboard or space was used for. An example of this may be where pictures of food and drink in the environment are used to help people to identify the dining area. The décor consisted of a number of different patterns and colours both within the flooring, walls and accessories such as curtains. This meant that people were at risk of increased confusion and distress and their independence being limited as the environment did not specifically cater for their diagnosis.

This was a breach of regulation 15 of the Health and social care Act (regulated Activities) 2014 as the environment was not well designed and did not offer suitable adaptations to support the needs of people living with dementia.

Staff told us that they had recently completed training in dementia awareness, moving and handling, food safety and first aid. Following our inspection the registered manager provided CQC with a copy of the staff training matrix for our review. We found that the matrix had not been kept up to date and identified that staff had not completed regular training updates in line with the registered providers own timescales. The training matrix showed that safeguarding adults training had only been completed by one staff member since 2014 and only two staff had received dementia dignity champions training since 2013. The last recorded session for staff on health and safety took place in 2013. The registered manager had failed to keep an accurate and up to date copy of the training completed by staff. This meant that people were at risk of receiving care and support from staff that did not have the appropriate up to date skills to ensure their safety and well-being. We spoke with the registered manager who assured us that they would update their records and provide an accurate copy to CQC. This was completed and confirmed staff had received training updates as required.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from the people supported about the care and support they received. They told us, "There is not a lot of stimulation for me. They cater more for older people" and "Staff don't really have the time to spend with me" and "The staff are so busy, I don't like to bother them". Other people commented, "I have no complaints. I get on with most of the staff, some more than others" and "Most staff are respectful. There have been a lot of changes and they always ask me about what I want. That's good, they don't just take stuff for granted'. Family members confirmed that they felt comfortable with the support their relatives received. Comments included, "It always seems perfect when I come, all [my relatives] needs seem to be met" and "I am happy with the service. They let [my relative] do their own thing. They can just potter about, they are very independent and like to be left alone".

When we inspected the service in January 2016, we identified concerns that people living in the service were not always supported or treated in a dignified and respectful manner. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and respect and we issued a requirement notice. We found that some improvements had been made.

People told us that staff had a good knowledge of their likes and dislikes and how they preferred to be supported. One person told us, "They always ask me what I need help with", another person said, "I have no complaints. They do things how I like it". Observations showed that staff were more caring in their approach towards people. We observed staff trying to encourage people to maintain their independence where possible. However, observations showed that some staff on the first floor were task orientated in their approach across the duration of our visit. An example of this was where people were assisted to use the bathroom. It was clear that staff started to help people to use the toilet prior to the serving of meals or drinks. Comments heard by staff such as, 'Is it time to start toileting people now, the dinners will be here soon', confirmed that there was a cultural practice of 'toileting times'.

At lunchtime staff were observed asking people where they preferred to sit and have their meal. Some people chose to eat their meal at the table, some people ate in their personal bedrooms. A choice of meals, cold or hot drinks and desserts were offered. Where a person expressed a dislike for the food options presented to them alternatives were made available. Staff were respectful of people's preferences. Staff on the ground floor worked hard to promote people's independence by encouraging them to eat their meal independently or by prompting people when required. However, on the first floor people were required to sit in their chair in the lounge and were not always offered the option to move and join other people at the dining table. This was due to the lack of space available. We noted that the television was very loud in the background and at times created a distraction for people from eating their meal. Staff were task orientated in their approach throughout the lunchtime meal. We spoke with a senior member of staff who confirmed that the mealtime experience was currently being reviewed. It was clear that there was an understanding of what improvements were required and some changes had started to be addressed.

On the first floor of the service staff spent little time sitting and engaging people in conversation to create the opportunity for social interactions. During our visit we saw that people sat in chairs around the lounge

walls and listened to the TV. People were not actively engaged in watching the TV and we saw no alternative options for interactions or stimulus created such as music, reading or games. One person became quite frustrated and left the lounge due to the loud noise from the television. People who were supported in their beds were regularly visited. However, we noted that any visits made by staff were to undertake a task such as helping the person to eat, drink or supporting them with their personal care needs. This meant people were at risk of becoming socially isolated and experienced periods of boredom and frustration.

Throughout the day we observed staff knocking on bedroom doors prior to entering to ensure people had privacy. Staff understood the importance of ensuring people's privacy was respected and were confident in describing how they protected people's dignity as far as possible in the way that they carried out personal care and support.

Visitors told us they were always made welcome at any time of the day. Family members commented, "Visitors are made to feel welcome here. I can have lunch, tea and coffee and there is never a charge for it" and "I am always made to feel welcome here. I always visit and have something to eat with [my relative]. That's important to me".

Records containing personal details were stored securely which ensured that people's confidentiality was maintained.

Inadequate

Is the service responsive?

Our findings

People's views varied about the care and support they received. They told us, "They always ask me if I need help" and "Sometimes they seem a little overstretched, but I get the help I need eventually. I know how busy they are". We saw that staff responded to people's needs and requests for assistance to use the bathroom and for refreshments. Family members told us, "I'm full of praise for the staff. [My relative] loves it here. They do their best, it's a hard job". However we found that the service was not responsive to people's needs.

Previously we had concerns regarding the lack of personalised, accurate and complete records in respect of people who used the service. Following our visit in January 2016 we issued a breach of regulation 9 of the health and social care act (regulated activities) 2014 and warning notice to the registered provider to ensure that records were reviewed and updated to meet the needs of people being supported.

We found that sufficient improvements had not been made. Care plans we reviewed were task orientated in their focus and did not evidence how a person preferred their care or support to be provided. Comments such as 'provide assistance with eating and drinking as required' or 'with personal care' were recorded on care plans. There was no information recorded to outline individual specific support needs in these areas. Care plans failed to evidence information regarding people's preferences for gender of carer, when to receive care, how to receive care and how people preferred their care and support to be delivered. Where people required support with moving and handling, there was limited or contradicting information in records as to how many staff were required to support people safely. An example of this was where a mobility care plan we reviewed stated that two staff were required for safe moving and handling, and the same person's epilepsy care plan identified that only one person was required for safe moving and handling. This meant that people were at risk of receiving unsafe care and support that was not sufficient to meet their needs.

Care plans included limited information regarding people's personal life history and were this was in place there was no evidence of how this was incorporated into people's daily support. Through discussions we found that staff had a varied knowledge and understanding of people's life history. Staff on the first floor told us that they mostly focused on getting to understand what a person's health care needs where. We saw no conversation or discussion regarding past history or life experiences. One person told us, "I was quite important in my work. We don't really have time to talk to the staff about what we did. They are so busy". This meant that care and support people received was not always personalised.

Supplementary records (day charts) used for recording food and fluid intake were not consistently completed. Where people had been identified as high risk weight loss we found large gaps in the information recorded spanning up to a 15 hour period. Care plans for one person stated 'recently lost weight, unable to maintain adequate nutrition – needs high protein, high calorie diet, and monitor refusal to eat'. We found that food and fluid intake was not recorded or evaluated on a regular basis. Records for another person who was on a weight reducing diet had only been completed for 6 days in total spanning over a 5 week period. Supplementary records did not clearly identify the amount of food and fluid that people required over a 24 hour period or what they had eaten or drank. Comments such as 'juice', 'tea' were

regularly written on the fluid intake diary and 'porridge', 'toast' or 'sandwiches' in the food intake section asking for 'diet intake'. This meant that people were not safely protected from risks of dehydration and inadequate nutrition.

This was a repeated breach of regulation 12 and 17 of the health and social care act (Regulated Activities) 2014 as accurate and contemporaneous records were not held in respect of people supported which may place people at the risk of receiving unsafe care or treatment.

People told us, "We have done some baking recently and I like the chair aerobics. That's really good". Relatives told us "[My relative] has been on a few outings. I think they take a few people out each week" and "A lady comes to do exercises each week. There are good activities here for [my relative] they keep them active". There was an activities co-ordinator at the service who organised and led activities. A notice board and monthly newsletter was displayed in the home that identified a range of forthcoming activities and events including weekly exercise sessions, religious services and a musical reminiscence group.

During our visit we saw some activities taking place such as a singing entertainer and a movement and exercise group on the ground floor. Through a review of care plans we saw information relating to meeting people's activity and social needs recorded on an activity log. Comments such as, ''X' made a foam blossom tree this morning in' and ''X' sat outside and played a ball game and decorated a tea light holder' were recorded.

People told us, "I know how to make a complaint, someone kept buzzing their buzzer and keeping me awake. I was helped to move rooms" and "I have no complaints but if I did I would speak to the nurse in charge". Family members confirmed they would be confident in raising any concerns they had directly with the registered manager. The registered provider had a complaints and compliments policy and procedure in place which gave details of who people could speak with if they had any concerns and what to do if they were unhappy with the registered provider's response. Following our inspection we were provided with a record of complaints that the registered provider had received since our last inspection and had acted upon and successfully concluded.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post and she had been there since 2011. People who lived at the service told us, "I know who the manager is, she is down to earth and I will go and talk to her if I need too" and "The manager is nice enough". Through discussions with family members during our visit we found that some knew who the registered manager of the service was and some did not. Comments included, "I'm not sure who the manager is. I would go and speak to the nurse if I needed anything" and "I would go to the manager if I needed anything she is approachable".

Previously we had concerns that the registered provider did not have effective systems and processes in place to monitor and improve the quality and safety of the service. We issued a warning notice to the registered provider.

The registered manager was on holiday at the time of our visit and had been away from the service for over a week. During our inspection we were unable to access information relating to the quality assurance audits that had been completed since our last visit. The registered manager's office was locked and the deputy manager who was acting as manager in her absence did not have a key to the manager's office. We requested that the registered manager forward information to CQC relating to quality assurance checks within a set timescale. This was completed.

Records provided showed that some improvements had been made to the Quality Assurance audit system. Audits were completed on a monthly basis by the registered manager for medication, accidents and incidents, falls and environmental checks. However we found that information recorded as part of the auditing process was not always analysed effectively. Accident and incident audits identified that between January and July 2016 there had been 24 incidents of 'slips and trips' at the service. Records showed that no analysis of the overarching reason for these slips or trips had been considered and there was no evidence to suggest that any actions had been taken to reduce or minimise the risk of further harm to people supported. The registered provider had not always considered if adjustments were needed to the premises, equipment or staff practices as the result of similar occurrences.

Issues we found as part of our inspection were not identified by the registered manager through the environmental audit process. Audits completed in July 2016 recorded that the décor across the home and in the bathrooms was in good condition and clean. Carpets were also recorded as being in good condition. However, throughout our inspection we identified areas where carpets or décor was in need of replacement due to wear and tear and unpleasant smells. We saw no evidence that concerns relating to infection prevention control had been identified and addressed. Through discussions with the director of nursing, quality and compliance manager and the senior team member, it was established that the registered manager was responsible for auditing the service and reported her findings directly to the registered provider. However, there was no evidence that independent quality assurance checks were completed by the registered provider to review information that was shared from the audit process. This meant that there had been a lack of accountability and oversight by the registered provider to ensure the quality and safety of the service provided to people.

A senior member of staff who worked at the service told us that they had recently introduced a new care plan audit which they would complete on a monthly basis. A range of areas were covered for review, including checks to ensure all relevant risk assessments and care plans were in place and up to date. However the completed care plan audit from June 2016 did not identify which care plan had been reviewed. Staff were unable to tell us which care plan had been reviewed and we noted that no actions for improvement or comments for consideration had been recorded. This meant that the audit did not allow for other staff to address any areas of development or concerns. We raised this with the director of nursing and the quality compliance manager who stated that more work was required on the document for its use to be effective.

The was a repeated breach of regulation 17 of the health and social care act (regulated activities) 2014 as the quality assurance systems in place at the service where not effectively used to assess, monitor and improve the quality and safety of care provided.

Family members we spoke with told us that they did not know what the current CQC rating of the service was. The registered provider had failed to display their ratings from the previous inspection. Inspectors undertook a thorough examination of the service and found no copies of the current ratings or report displayed on the premises. The registered provider's website was reviewed prior to the inspection and the current ratings and CQC report were not available for public viewing.

This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to display their ratings.

Staff confirmed that team meetings had taken place at the service and these were used to share information and update people on any changes that had occurred. Minutes we reviewed showed that required checks on equipment and the environment were discussed. Information relating to policy and procedures and the importance of the nurse handover procedures and sharing of information with carers were also recorded.

Staff told us that they felt morale had been low at the service. We were informed that there had been a high turnover of staff since our last visit and staff had felt at times there was not enough support received from the management team. We were concerned that a number of staff did not know when the registered manager would be in attendance at the service. CQC have contacted the service on a number of occasions since our last visit and staff have been unable to advise when the registered manager would be available. Rotas confirmed that her hours were not recorded so that staff would know when she would be available. We spoke with the registered manager following our visit who confirmed that staff have her contact number and could call her at any time. The Director of Nursing stated that this was not a usual practice and this would be addressed immediately.

The registered manager confirmed that resident and family meetings had not been successful at the service. Feedback they had received from people had been that as there was an 'open door' policy in the home, they felt there had not been a need to attend the service. Discussions were taking place as to the introduction of coffee mornings which would give people the chance to come together on a more informal basis. The registered provider had undertaken an annual feedback survey with people supported in August 2016. We spoke with the registered manager following our inspection who informed us that she was in the process of reviewing feedback and comments for action. Two people had made suggestions for improvements regarding the car park and also the use of staff name badges to help with familiarity. This demonstrated that the registered provider took account of people's opinions and feedback.

Registered providers are required, by law, to notify us about and report incidents to other agencies when

deemed necessary so they can decide if any action is required to keep people safe and well. The registered manager had informed the CQC of specific events or incidents that had occurred at the service.

The registered provider had a set of policies and procedures in place. We reviewed the medication, mental capacity and deprivation of liberty safeguards policies and the company policy on restraint. We noted that policies made reference to current legislation and best practice guidance. A policy folder was made available for staff to access and specific policies were discussed via the team meetings.