Four Seasons (No 9) Limited

Bon Accord

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days on 31 May 2017 and 7 June 2017. Bon Accord is a nursing home providing accommodation for people who are living with dementia and who require support with their nursing and personal care needs. Many of the people had difficulties in communicating their needs. This meant that they were at risk as they were unable to raise concerns or make basic decisions about their care and welfare needs. Bon Accord is registered to accommodate a maximum of 41 people, as some of the rooms are large enough for dual occupancy. However, rooms had been converted and were single occupancy; therefore a maximum of 33 people can be accommodated. There were 27 people living in the home at the time of the inspection. The home is a large property situated in Hove, East Sussex; It has three communal lounges, two dining rooms and a garden.

The home is owned by Four Seasons (No9) Limited, which is part of a large national corporate provider called Four Seasons. Four Seasons (No9) Limited own a further three care homes in England. A registered manager is a '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 home is run. The home did not have a registered manager in post at the time of the inspection. An acting manager was in post and they were present on the first day of the inspection.

At the last inspection on 6, 7 and 15 February 2017, we found multiple breaches of the regulations. The service was rated as inadequate overall and was placed in special measures. We undertook a comprehensive inspection on 31 May and 7 June 2017 to check whether the required actions had been taken to address the breaches we previously identified. This report covers our findings in relation to these requirements.

Although there had been some improvements we found continued breaches of the Regulations. The overall rating for the service remains as Inadequate and the service therefore continues to be in 'Special measures.' Services in special measures will be kept under review and, if we have not taken immediate actions 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. You can see what actions we have taken at the end of the full version of this report. The 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.

At the last inspection on 6, 7 and 15 February 2017 medicine management was inadequate, there was unsafe moving and handling practice, failures in following health care professional's advice and the lack of effective risk management placed people at serious risk of harm. At the inspection of 31 May and 7 June 2017 it remained that management of people's medicines was not consistently safe. Improvements had been made to ensure that people had access to the medicines they needed but there were continued concerns regarding inconsistent practice in administering medicines.

Risks to people were not always managed effectively, this meant that some people who were living with diabetes were not being supported to manage the risks associated with their illness. Wound care and skin integrity were not always effectively managed because risk assessments and care plans had not been completed to guide staff. Systems for ordering wound dressings were not operating effectively and this meant that people were not always receiving the wound care treatment that had been prescribed by a health care professional. Referrals to health care professionals were not always made when people's needs changed. This meant that there was a continued breach of the Regulations.

There was a lack of organisation, co-ordination and planning to address risks of social isolation. Although two activity co-ordinator posts had been filled they were not yet operational and there was a lack of planning and co-ordination to support staff in providing meaningful occupation and activities for people. Some people were at risk of continued social isolation as they spent extended periods of time in their rooms. Some measures were in place with regular checks to ensure their health and safety however there were no plans in place to identify how risks of social isolation could be mitigated for people.

Governance arrangements were not always effective in identifying issues with quality. For example, some audits had identified areas for improvement however actions were not always taken to address these issues. Management oversight was not always effective. For example, records indicated changes in people's needs, however it had not been recognised when appropriate actions, (such as a referral to a health care professional), were not taken. Poor practice observed when administering medicines had not been addressed. Lack of appropriate care planning for wound care had not been recognised and acted upon. This means that there was not an effective clinical governance system in place to ensure that people received responsive care.

People's care records continued to not always reflect the needs and care requirements of people and people were at risk of receiving inappropriate care because records were not up to date and accurate. Some care plans had been updated but the majority had not yet been reviewed. Some people were subject to Deprivation of Liberty Safeguards (DoLS) because they lacked capacity to make certain decisions and needed continuous supervision. Staff were aware that people were subject to DoLS and had an understanding of their responsibilities with regard to the Mental Capacity Act 2005. Some people had conditions attached to their DoLS authorisations such as ensuring that they were supported to go out on a regular basis. However the provider had not ensured that these conditions were consistently met.

People and relatives told us that staff were caring and kind and we saw many positive examples of sensitive and compassionate interactions between people and staff throughout the inspection. However there were some areas of practice that continued to require improvement. One person had fallen in their room and staff called the paramedics as they had banged their head. No staff member remained with the person while they waited for the paramedics to arrive until an inspector intervened to obtain support for the person as they were observed becoming distressed. People were not always wearing clothes that reflected their identity

and this meant that their dignity was not consistently promoted and their choices were not always considered and respected.

People and their relatives spoke highly of the new manager at Bon Accord. One person said, "It is much better, I think it is generally a well -run home." A relative said, "There have been a lot of improvements, it's much better and the atmosphere has improved." Staff were also positive about the changes, one staff member said, "We still have a long way to go but things are so much better. I can now go home and sleep knowing that people are being cared for." Another commented, "There was no leadership before, now we have a strong manager who listens and acts."

Staff had received training and support to ensure that they had the knowledge and skills to be effective in their roles. We saw that they were competent and confident in assisting people to move with the use of equipment such as a hoist. Some people who were living with dementia presented behaviours that could be challenging to staff. Specific training had been arranged to assist staff in responding to these situations. Staff told us that this had a positive impact and had helped them to be more effective when providing support. One staff member said, "I feel much better at de-escalating situations and have a better understanding of why sometimes, people behave as they do."

Staffing levels had improved and people said that there were enough staff on duty. One person said, "The staff are very good and always come if I press the bell. I don't usually have to wait long." A staff member said, "Staffing is better." Our observations confirmed that there were enough staff to care for people safely. People were supported to have a pleasant meal time experience and staff were attentive in ensuring that people had enough to eat and drink.

The provider had ensured that there was additional support for the acting manager and gave assurances that this would remain in place whilst the home continued to make improvements. The acting manager demonstrated a clear vision for the home and was transparent and honest regarding current shortfalls. We found that improvements had been made since the last inspection but there remained a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe.

Risks to people were still not being managed effectively to keep people safe.

People's medicines were not always managed safely.

There were enough staff to care for people safely. Recruitment checks ensured that staff were suitable to work with people. Staff understood their responsibilities with regard to recognising and acting upon abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity to consent to care and treatment was not always sought and conditions associated with DoLS authorisations were not being consistently met.

People were not always supported to access health care services when they needed them. Most people had been supported to have enough to eat and drink, some risks associated with malnutrition were not being effectively managed.

Staff were supported to carry out their roles effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not consistent in supporting people's dignity.

Staff knew people well and had developed positive relationships with people.

People were supported to make choices

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not always responsive to changes in their needs. Care plans were not all updated and accurate.

People were not supported to have enough to do and risks of social isolation were not effectively managed.

People and their relatives knew how to make a complaint and felt comfortable to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Governance systems were not always effective in identifying areas for improvement.

Staff were well supported and morale was good.

There was clear leadership and staff were aware of their roles and responsibilities.

Bon Accord

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 31 May and 7 June 2017 and was unannounced. This meant that the provider did not know that we were coming. The inspection team on the first day of the inspection consisted of three inspectors, one of whom was a pharmacy inspector. One the second day of the inspection there was one inspector, a pharmacy inspector and an inspection manager.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. We reviewed information sent to us by the Local Authority and the Clinical Commissioning Group who had carried out joint quality assurance visits since the last CQC inspection.

We had not asked the provider for a Provider Information Return (PIR) before this inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We spoke in detail to five people who use the service and five relatives. We interviewed eight members of staff and spoke with other staff during the inspection. We spoke with the acting manager, the regional interim support manager and the regional manager. We looked at a range of documents including policies and procedures, care records for 14 people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's information systems. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experiences of people who could not talk with us. We observed care and support in the communal lounges, dining rooms

and in peoples' own rooms during the day. We also spent time observing the lunchtime experience that people had and the administering of medicines.

The last inspection on 6, 7 and 15 February 2017 identified multiple breaches of seven Regulations and found the service to be inadequate overall.

Inadequate

Is the service safe?

Our findings

At the last inspection on 6, 7 and 15 February 2017 we found that people were not always receiving safe care and treatment and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicine management was inadequate, there was unsafe moving and handling practice, failures in following health care professional's advice and the lack of effective risk management which placed people at serious risk of harm.

At the inspection on 31 May and 7 June 2017 there had been some improvements with regard to management of medicines and manual handling practice however there remained concerns about some aspects of administration of medicines, and the continued lack of effective risk management for some people. This means that there is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Measures to improve the system for ordering medicines had been implemented and sustained. The acting manager and the deputy manager had introduced systems to ensure that medicines were ordered and checked in a timely and consistent way. This ensured that people's prescribed medicines were accessible when they needed them. We looked in detail at Medication Administration Record (MAR) charts for 10 people. Staff told us that daily audits of MAR charts were carried out to monitor their completion. We noted that all MAR charts were completed correctly. This confirmed that people had been receiving their medicines and our observations verified that people's prescribed medicines were in stock and available. Medicines were stored at correct temperatures and appropriate arrangements were in place to dispose of unwanted medicines.

Despite these improvements we found that some aspects of medicine management remained inconsistent. We observed medicines being administered on both days of the inspection with a registered nurse and a care worker. The registered nurse was a member of agency staff but the acting manager said that they were familiar with the home and had worked there a number of times before. The provider's policy for safe management of medicines was not always followed. For example, one member of staff was administering medicines to people and they told us that this was taking longer than expected. Some people had to have their medicines at specific times and they were prioritised to ensure they had their medicines when they needed them. Other people were having their medicines later in the morning. This meant that for some people, the time of their next dose of medicine would need to be adjusted to ensure that the time between doses was safe. The staff member who was administering the medicines was aware of this and told us that they would delay the time of people's next dose to accommodate this. However the specific time of administration of medicines were not recorded. This meant it could not be assured that the time between doses was safe.

The Nursing and Midwifery Council (NMC) Standards for Medicine Management states that 'The Registrant must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine. Where medication is not given, the

reason for not doing so must be recorded.' It is recognised as good practice for the person who is administering the medicine to sign the MAR chart after they have seen the person taking the medicine. Our observations were that a registered nurse signed the MAR chart before the medicines were given. This meant that there was a risk that records were not accurate. For example, one person was asleep when they were offered their medicines and therefore they were left it in the medicine trolley until later in the morning. However the MAR chart had already been signed and therefore it appeared that the person had already had their medicine. Although we saw that the medicines were given later when they were awake this practice could have resulted in the person not receiving the medicines they required.

We observed a registered nurse leaving a person's prescribed medicines on the table in front of them when they refused to take a tablet. The person's relative had been visiting at the time and later told us that they had disguised the tablet in a piece of sponge cake which they had given to their relation. The NMC standards for medicines management, state 'You must be certain of the identity of the patient to whom the medicine is to be administered'. It goes on to state, 'A registrant (in this case the registered nurse) is responsible for the delegation of any aspects of the administration of medicinal products and they are accountable to ensure that the patient, carer or care assistant is competent to carry out the task'. By not administering the medicine themselves the registered nurse was not certain that the person, for whom the medicine was prescribed, took their medicine. They did not delegate the administration of medicines to a person who they had deemed competent to carry out the task.' By not following the NMC standards there was a risk that the person would not be given their medicines or that another person could be administered a medicine for which they were not prescribed. In this case the person had received their medicine covertly although there was no agreement in place to show that this was in their best interests.

Each MAR chart contained a photograph of the person for whom medicines were prescribed. This enabled whoever was administering the medicine to make a visual check to identify that they were administering medicine to the person for whom it was prescribed. We observed a registered nurse administering medicine to a person who they did not know. Instead of checking the photograph on the MAR chart, the registered nurse asked a passing member of staff if this was the right person. This meant that the registered nurse had not followed the correct procedure to ensure they were certain of the person's identity before administering the medicines.

A lockable medicines trolley was used to ensure that medicines were kept securely. We observed that on one occasion the trolley was left unattended with the keys for a few minutes. This meant that medicines were not secure during this time.

Some people were receiving their medicines covertly. This is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. Covert administration is only likely to be necessary or appropriate where a person actively refuses their medicine but is judged not to have the capacity (as determined by the Mental Capacity Act 2005) to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. Where people were receiving their medicines covertly we saw that mental capacity assessments and best interest decisions were recorded in line with the Mental Capacity Act 2005. However not all best interest decisions for covert medication had been reviewed, for example when someone's medicine had changed. This meant that the provider could not be assured that the decision to provide medication covertly remained in the person's best interest and that the method for covert administration was still safe and suitable for the medicine prescribed.

Some people needed insulin injections to manage their diabetes safely. We saw that insulin bottles had not been labelled with the date that they were opened. Insulin must be used within a specific timescale from the

date it is opened it was not possible to establish if the medicine remained within its expiry date and was therefore safe to use.

Changes to people's prescribed medication were not always clearly documented. For example, one person had the morning and the evening dose of their medication changed. A letter from a health care professional dated 11 May 2017 confirmed the change of dosage. The information on the MAR chart had been amended to indicate the new dose. However there was no date to indicate when this change had been made. This meant that the MAR chart indicated that the person had been receiving this dose of medicine since the beginning of the month. The daily notes for the person indicated that there had been a change of dose on 11 May 2017 however information recorded was not consistent with the information in the letter and on the MAR chart. This meant that there was not a reliable, accurate record of medication administered for this person during that month.

Continued failures in managing medicines means that there remains a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always managed effectively. Some people had diabetes and their care plans showed that they needed to have their blood sugar levels monitored regularly. One person's care plan indicated that they should have their blood sugar levels monitored once a week, however records demonstrated that readings had been taken on only three occasions in the previous two months. There was no explanation recorded for the missed monitoring. There was no risk assessment or care plan in place for the management of diabetes. This meant that there was no clear guidance for staff about the signs or symptoms that might indicate a high or low blood sugar level. There was no indication in the person's care plan of what an acceptable range was for their blood monitoring and what action to take in the event that the readings were outside of this range.

Another person needed to have blood sugars monitored twice a day before meals and was prescribed insulin by injection. A care plan for 'significant/specialist intervention needs' stated 'If she develops Hypo or Hyper call 999, if no medication in place.' There was no other guidance for staff as to what signs or symptoms to look for that would indicate a hypo or hyper situation. There was no protocol to give clear guidance about what this persons acceptable range was for blood sugars and what to do in the event that readings were outside of this range. This meant that some people who were living with diabetes were not being supported to manage the risks associated with their illness safely.

One person was being treated for pressure wounds, including a category four pressure wound. (A category four wound indicates a full thickness tissue loss with exposed bone or tendon.) A small team of Tissue Viability Nurses (TVN) had been visiting regularly to treat the wound and a TVN care plan was in place. However this information had not been translated onto a wound care plan for staff at Bon Accord to follow. This meant that care staff did not always have clear guidance to follow. The TVNs recorded their visits and included relevant advice for staff, however there was no updated care plan and this meant that instructions were not always followed. For example, on more than one occasion the TVN advised that staff should order specific dressings as stocks were low, the following week they recorded that the order had not been implemented. This lack of equipment meant that the person's wound had not been treated with the prescribed dressings. Another example showed that the TVN had suggested that the person could trial sitting out of bed twice a day for up to 2.5 hours. This was recorded in the daily notes for the date of the TVN visit. However they also requested that staff 'Assess that this is not detrimental to the wound daily.' This was not recorded in the person's daily notes and there was no record to show that staff had monitored the wound as requested. Another TVN note advised that to aid healing the person should not sit out of bed for more than 2 hours each day. They noted that the person was happy with this time and advised staff 'Please

do not go over this time limit.' However, daily records gave no information in order to be able to monitor the instructions from the TVN about how long the person had sat out for each day. A recent TVN record stated 'Daily evaluation notes are vague and do not include progress of wounds.' They also noted that the wound was not improving.

A second person was under the care of a TVN and they had advised that a barrier cream should be applied four times daily to protect their skin integrity. A care plan was in place however it did not include the instruction to apply a barrier cream. This meant that staff did not have clear guidance about how to care for the person. The person's skin integrity had not been reassessed and the care plan had not been reviewed since February 2017. Records demonstrated that the cream was not being applied consistently. There were recorded applications on 16 occasions in April and six occasions in May 2017. Staff had recorded 'None in stock' on two dates in May 2017, the last time an application of barrier cream was recorded was 12 days before the inspection.

Another person was seen to have a wound dressing on their right leg. There was no record of when the dressing had been applied. Daily notes made reference to a dressing on their left arm and to a wound on the leg but there was no wound care plan in place and a skin integrity care plan had last been reviewed in March 2017. A risk assessment tool had been used to assess the risk for this person of developing a pressure sore. The risk had last been calculated in January 2017 and was scored as a medium risk. Recent daily notes for this person showed that staff had noticed changes to some areas of skin noting that they were 'red and sore' however there had been no changes to the care plan or risk assessment. A monthly review for skin integrity indicated that an emollient cream was being applied daily. However records showed that this was not happening consistently. The cream had been recorded as being applied for only four days in April and nine days in May 2017.

We discussed the lack of risk assessments and wound care plans with the acting manager. They agreed that skin integrity care plans should be updated and robust wound care plans were needed. On the second day of the inspection we were shown that actions had been taken to introduce a new system to ensure that wound care was managed more effectively. Continued failures to assess and manage risks to people means that there remains a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 6, 7 and 15 February 2017 we found that people who were at risk of malnutrition were not being effectively supported to have enough to eat and drink. At the inspection on 31 May and 7 June 2017 we found that whilst some improvements had been made there remained some areas of practice that were inconsistent and needed to improve.

One person was assessed as being unable to manage their nutritional needs as they were living with dementia. A care plan to support their nutritional needs was in place and stated that they had a history of weight loss and that their weight required 'close monitoring.' The care plan had not been reviewed since January 2017. Staff had noticed a change in the person's needs and had made an appropriate referral to the Speech and Language Therapist (SALT) in February 2017. Advice from the SALT included being offered a soft diet and being assisted by staff to eat and drink. The nutritional care plan had not been updated to include this information. A Malnutrition Universal Screening Tool (MUST) had been used to calculate the risk for this person in January 2017 but the risk had not been reviewed since then. Monthly weight monitoring had not been recorded for April or May and this meant that the provider could not be assured that SALT guidance was being followed and that the person was maintaining their weight.

Another person had an unplanned weight loss recorded in February 2017. A referral was made to the

dietician who recommended food fortification. This was reflected in the monthly review which guided staff to 'Encourage with meals and to offer milk shakes during tea times.' Despite these positive actions the person continued to show a weight loss since February of 8.4 kg. There had been no further review recorded to show any other actions that might be needed to further address their weight loss. This meant that the provider could not be assured that appropriate steps were being taken to support this person to maintain their weight. We looked at the records for five other people who were assessed as being at risk of malnutrition. This showed that people's weights were being monitored and actions had been taken to ensure that they were receiving the support they needed to eat and drink. This showed that the provider had made improvements in ensuring that staff followed guidance to reduce risks of malnutrition and dehydration. However as practice in this area was not fully embedded and consistently sustained this remains an area that needs to improve.

At the last inspection on 6, 7 and 15 February 2017 people were not always protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 there were improvements in supporting people who had behaviours that could be challenging to others. This meant that the previous breach of Regulation 13 had been addressed and changes in systems had been embedded and maintained.

Most staff had received training in safeguarding adults since the previous inspection. Staff demonstrated a firm understanding of their responsibilities with regard to identifying and reporting safeguarding issues to ensure that people were protected. At the previous inspection in February 2017 we had identified concerns that some people, who were living with dementia, were being inappropriately restrained. At this inspection we found that the provider had taken steps to ensure that there were appropriate arrangements in place to support people who had behaviours that could be challenging.

The acting manager told us that introducing more effective ways for staff to support people ensured that there was no longer a need to restrain anyone. We were told that some staff had received Distress Reaction Training provided by a dementia nurse. Staff spoke highly of this training and described the positive impact it had. One staff member explained that receiving support with personal care was a known trigger for one person who often became very distressed. They described how they used the techniques learned to build up over twenty to forty minutes before providing personal care. This was said to help the person to know what to expect and to understand what was happening. One staff member said, "It can still be difficult and hard work, but it is much better." The care plan for the person had been reviewed and provided clear guidance for staff in how to support the person if they became distressed. It indicated the known triggers that might cause the person to become distressed and described techniques and strategies for staff when this happened. Staff were consistent in telling us about this person's care plan and spoke positively about the change of approach that had been implemented. One staff member said, "I feel more confident now. We record anything that we notice causes (person's name) to become agitated or distressed." Another staff member told us, "I particularly liked the training supporting people with challenging behaviour. I feel much better at de-escalating situations and have a better understanding of why sometimes people behave as they do, yes it was really good training, I feel so much more confident. I have changed my approach following the training as I am more aware of triggers as to why someone behaves as they did and I didn't always understand why in the past."

At the last inspection on 6, 7 and 15 February 2017 staffing levels and the deployment of staff were not sufficient and did not allow for people to receive safe, personalised and individualised care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 we found that there had been improvements in the deployment of staff and this breach of regulations had been addressed.

People and their relatives told us that they felt there were enough staff to care for people safely. One person said, "The staff are very good and always come if I press the bell. I don't usually have to wait long." A visitor told us, "I have no concerns about staffing at the moment, it has improved a lot." A relative said, "The staff are always busy but the staffing levels seem ok." Another relative said, "It's much better than last year, they check (person's name) every two hours." A third relative told us, "Staff numbers seem to be much better, there's more continuity. " Throughout the inspection we found that call bells were answered quickly .

We saw evidence that people were being checked by staff regularly and that there were enough staff on duty during busy times of the day such as at meal time. Staff told us that there had been an improvement in staffing levels since the previous inspection. One staff member said, "Staffing levels are OK, it is busy but I never feel rushed. Staffing wasn't that great before but it has improved." Another staff member told us, "Staffing is better." A third staff member said, "I definitely feel that there is less falls as there are more of us around now to prevent things like that happening." Staff rotas confirmed that staffing levels had been consistently maintained. The acting manager explained that some staff had transferred from another local home and that this had helped to improve the situation. They told us, "We only have to use agency staff for occasional shifts now, it has helped the continuity." The provider had not admitted any new people to the home since the previous inspection. The acting manager said, "Although our occupancy levels have reduced we have maintained the same number of staff on shift." Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role, this included criminal records checks with the Disclosure and Barring Service (DBS) as well as obtaining two references .The provider also had a system in place to check the nurses were registered with the NMC.

Staff told us they had completed recent manual handling training and this was confirmed in training records. We observed that staff were confident when assisting people to move around. We observed staff assisting people to transfer between a wheelchair and armchair with the use of a hoist. Staff were confident and professional in their approach, they ensured that the person's dignity was protected and spoke reassuringly to them throughout the manoeuvre. People had manual handling risk assessments and care plans in place and we saw that staff were providing care that was consistent with people's care plans.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 6, 7 and 15 February 2017 we found that people's rights were not always protected because their capacity to give consent had not always been assessed and relevant people were not always involved in the decision making process when people lacked the capacity to give their consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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).

At the inspection on 31 May and 7 June 2017 we checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. Records showed that there remained an inconsistent approach to assessing people's capacity to consent to their care and treatment. Whilst some mental capacity assessments had been completed practice in this area was not embedded and sustained. Conditions of DoLS authorisations were not always met.

One person's care plan stated that they 'did not have capacity' however the level of need was described as 'moderate' due to 'fluctuating capacity.' The care plans relating to various elements of the person's care all stated that the person did not have capacity. One care plan stated, 'Care plan formulated in (person's name)'s best interests.' However there were no mental capacity assessments relating to specific decisions and no record of the best interest decision making process. This demonstrated that due consideration had not been given to whether the person was able to consent to any aspects of their care and consultation with relevant individuals regarding best interest decisions was not recorded.

Most people living at Bon Accord were living with dementia or had mental health problems. DoLS applications had been submitted to the local authority when staff had recognised that people's freedom was being restricted. A system was in place to ensure that every DoLS authorisation was in date and applications to renew DoLS authorisations happened in a timely way. Some DoLS authorisations were subject to conditions imposed by the local authority. Not all conditions that had been imposed were being met by the provider. A condition for one person stated that a particular best interest decision that had been made, regarding a restriction on their freedom, should be recorded in their care file. However this could not be found. Another condition stated that the person should be supported to go out at least once or twice weekly, however daily notes showed that this condition had not been met. Another person had a condition attached to their DoLS authorisation that medicines that were being administered covertly would be reviewed by the GP by a specific date. There was no record that this had happened. A third person had a condition which stated that their 'Interests and hobbies should be documented with details of how staff can

support these and a record to be kept of all offers and participation in activities.' These details had not been recorded.

A number of other DoLS conditions were being met. A paid advocate told us, "I did have concerns previously because DoLS conditions were not being met for the people I advocate for, however things have improved with the new manager." We observed that staff had an understanding of the importance of gaining consent from people. We noted that staff knocked on bedroom doors before entering and throughout the day we heard checking with people before providing care. Handover forms included information for staff about people who were subject to DoLS and staff were able to demonstrate their understanding of MCA and DoLS. Where restrictions to people's freedom were in place the least restrictive option had been implemented. For example, some people were provided with sensor mats and low profile beds to ensure their safety without restricting their movements.

Improvement in staff understanding and record keeping in relation to MCA and DoLS was evident. We heard staff checking with people before offering support and staff had an understanding of MCA and their responsibilities. However, practice in this area remained inconsistent and improvements had yet to be fully embedded and sustained. There remains a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 6, 7 and 15 February 2017 we found that not all people received safe care and treatment and there were concerns with regards to timely access to additional healthcare services. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 we found that some improvements had been made and most people had received help to access health care services when they needed to. However we found that some areas of practice continued to require improvement.

One person had unstable diabetes and their blood sugar levels were monitored regularly in line with their care plan. We noted that some of the readings had been very high. We asked staff what they would do if readings were at a high level. A registered nurse said that they would consult the GP. Records showed high readings recorded on three consecutive dates but staff did not seek advice from a health care professional such as the diabetes nurse or the GP. The person had been admitted to hospital on two recent occasions as a result of their diabetes. A safeguarding alert was raised with the local authority regarding this failure to seek medical advice. This failure to seek clinical advice is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection, CQC were notified of a safeguarding concern relating to a failure to recognise and take action when a person developed a urinary tract infection. Arrangements had been put in place to monitor this person's urine on a weekly basis as they were prone to developing infections and this was known to have a detrimental effect on their behaviour causing them to become more agitated and aggressive. Although the checks were being taken a positive reading had not been reported to the GP and staff had failed to recognise signs and symptoms of a urine infection. The acting manager had undertaken an investigation into this matter and put systems in place to ensure that this would not happen again. We found that these measures were in place and there had been no further incidents of this nature.

Many examples were seen where people had received the healthcare support they needed. Examples included referrals and involvement with Speech and Language Therapists (SALT), Tissue Viability Nurses (TVN), Dieticians, Specialist Diabetic Nurse, Older Peoples Mental Health Team, Chiropodist and GPs.

At the last inspection on 6, 7 and 15 February 2017 we found that the provider had not ensured that all staff

received appropriate support, training and professional development to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 there had been improvements in the level of support and training provided to staff and this breach of Regulations had been addressed.

Staff told us that they had received additional training and support in the three months since the last inspection. One staff member said, "There has been a lot of training since the last inspection, I have done moving and handling, care planning and end of life training. All very good. " Another staff member told us, "I have had recent training on moving and handling and dementia awareness. I am looking forward to the Distress Reaction Training which sounds really good." A third staff member said, "We have had a lot of training recently, including Distress Reaction Training. That was very good, I learned about the importance of knowing residents, what they like and if we are stressed they are more likely to be stressed." Staff told us how this training had helped them to become more effective in their roles. One staff member described how they had found the Distress Reaction Training particularly useful in supporting a person who was living with dementia and sometimes displayed behaviours that could be challenging for staff. "The training was really useful in helping (person's name). Before the training I struggled to support them but now I feel more confident." Another staff member said, "We had the dementia nurse come in and train us and it has helped with our approach."

People and their relatives said that they were confident that staff had the knowledge and skills they needed. One person said, "The care is good, the regular ones are good and know what they are doing." Another person said, "They keep on top of things, I think they are trained." A relative said, "It has improved a lot, staff are looking after (person's name) well, they check every two hours, I've seen the recording and I am often here when they come in to check. I think they do know what to do and have had training." Another relative said, " I think they provide good care overall, sometimes they have staff who don't know people so well but on the whole I think it is definitely getting better. They are trying to provide better continuity. I have seen them hoisting my relation and they are very good, even though she hates it they know how to reassure her and it's done efficiently."

Training records confirmed that since the last inspection, most staff had received manual handling training and some staff had received some specific training in supporting people who were living with dementia. There was an on-going training programme and the acting manager told us that all staff had access to the training they needed to ensure they had the skills and competencies for their roles.

The provider had arranged a number of listening sessions with their human resources team. This was designed to support staff to discuss any concerns that they had. They reported that staff morale had improved following these sessions. One staff member said, "It's a lot better, the atmosphere has improved," another staff member said, "Communication has improved and we are a much better team now." A third staff member said, "Things have much improved, we are now fully staffed and we all work together." Some staff members had additional responsibilities as Care Home Assistant Practitioners (CHAP). This role was designed by the provider for senior carers to take on additional responsibilities when trained and supervised by a registered nurse to do so. Some staff told us that because there had previously been high use of agency nurses they had not always felt that they were being properly supported in the role. However, staff told us that they felt better supported now and were confident that the right training and support was available to support them in their roles

The acting manager had started to provide supervision to staff. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues.

Staff told us that they had found the supervision meetings helpful. One staff member said, "I had my first supervision this month, it was very good. She (acting manager) asked me how I was doing and we talked about how I can improve. It was really helpful." Another staff member said, "We will now be getting supervision every three months and (acting manager) is very approachable and supportive." The supervision programme had only started during the month of the inspection and it was not yet embedded and sustained within the home. This is an area of practice that needs to improve. Staff members all confirmed that they felt well supported by the acting manager and spoke highly of the support they had received recently. A number of staff meetings had been held and records showed that these had been well attended.

Our observations on both days of the inspection were that staff were proactive in supporting and encouraging people to eat and drink. People's experience at meal times had improved since the last inspection and staff were providing the support people needed. For example, one person was being supported by a staff member but was not eating their meal. Another member of staff advised them to try another approach by talking about something different. The staff member tried this and the person started eating. People were offered a range of drinks and snacks between meals including sandwiches, fresh fruit, creamy puddings, cakes and biscuits. Staff offered people choices and encouraged them to have milkshakes to improve their calorific intake where needed. We observed one person who was at risk of malnutrition telling a member of support staff (not a care worker) that they were hungry, the staff member immediately responded saying, "Right, what can I get you?" and went straight away to bring the person's chosen soup.

People and their relatives told us that they were happy with the food. One person said, "It is usually good and you get a choice." Another person was heard to say, "What a nice meal I have just had." A visitor told us, "Staff always offer me a meal if I come at lunchtime and it looks very good." A relative said, "I am often here at meal times and the staff are attentive and help people who need it." Another relative said, "I think the food is pretty good, it looks home -made and my (relation) seems to enjoy the food." Risk of dehydration was being effectively managed. We saw staff offering people drinks throughout the inspection and encouraging and assisting people to drink. Fluid charts were being completed consistently and although the total for each day was not always included, in order to monitor whether people were having enough to drink, we could see that people were having reasonable levels of fluids to help prevent dehydration. We observed a member of staff completing two hourly checks for people who were spending the day in their bedroom and noted that they encouraged the person to have a sip of their drink and made sure they could reach their drink before leaving them.

Requires Improvement

Is the service caring?

Our findings

At the last inspection on 6, 7 and 15 February 2017 we found that people were not always respected or treated in a dignified way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 there had been some improvements however there remained an inconsistent approach to maintaining people's dignity and providing a caring service resulting in a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of the inspection one person had a fall in their bedroom. Staff, including the registered nurse, checked them and, as they had banged their head, the paramedics were called. Our observations were that whilst waiting for the paramedics to arrive the person was left unattended. It was not until the inspector asked if anyone was with them that a staff member was requested to sit with the person. The person was clearly distressed and shaken by their fall and leaving them alone did not demonstrate a caring response.

Most people were supported to dress in clothes of their choice and to express their personality through their appearance. One person was supported to wear bright clothing matching jewellery and bright glasses in keeping with her personhood and preferences. They said, 'The girls help me to choose what I would like to wear each day, I love bright things.' However we noted that there were no people wearing tights or stockings and it seemed unlikely that this was a preference that every person had made. One man was wearing a shirt and presented a proud and upright demeanour however he was seen to be wearing track suit bottoms that did not appear to be in keeping with his personhood. There was nothing in his care plan that suggested a need or preference for track suit bottoms. The regional support manager agreed that this choice of clothing may not have been the choice of the person and was not supportive of his dignity.

People were not being supported to maintain their diversity, sexuality or religion. For example, staff told us that there was currently no reference in care plans to people's sexuality needs and that they had "Some way to go" to ensure that their needs were understood and supported. Some people's care records made reference to their religious beliefs but there was no care plan to identify what support was needed. A staff member told us that there used to be regular religious services held at the home but that this had not happened for "a long time." People were not always supported in a caring way. Their dignity was not consistently promoted and people's individual personhood was not always considered and respected. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that the staff were caring and some spoke of the improvements since the last inspection. A person told us, "The care is good, staff are really wonderful, they treat people with dignity and are always respectful. I can't fault them." A visitor said, "I have noticed a difference since the new manager took over, staff are happier and that shows. They are very good with the residents." One relative said, "It is much better now, there are more regular staff and fewer agency so that has made a big difference." Another relative said, "Things are definitely improving and the staff are less stressed and able to

give a bit more attention to people. They are very caring." A third relative said, "The care is good overall, the staff are better now, there's more consistency."

Staff respected people's privacy and were mindful to preserve their dignity when assisting them with care. For example, we observed that staff took care to protect a person's dignity when they supported them to move with a hoist. Staff knocked on people's doors before entering and used their chosen name when speaking to them. One person preferred to be addressed formally as Mr. X and this was heard to be respected by staff. People responded positively to staff and appeared comfortable and relaxed in their presence.

Throughout the inspection we observed staff offering choices to people. One staff member spoke about the importance of helping people to remain independent by saying, "By giving people choices it helps to keep people's independence. We try and let them do as much for themselves as possible, it's hard sometimes not to take over." We heard staff asking people where they would like to sit, offering people choices of drinks and snacks during the morning and encouraging them. One staff member was heard saying "I know you'd like a nice cold drink, it's such a hot day isn't it." People told us that they could choose when they got up and went to bed. One person said that they felt their choice was respected but they were sometimes prevented from getting up at the time of their choosing due to staffing issues. They told us, "If they are short of staff I have to wait until they can help me, they give me priority if I have an appointment, otherwise I just have to wait." Staff told us that this was only the case if there was unplanned absence such as sickness at short notice. One staff member said, "Staffing is much better now and it means we are able to be more flexible with people most of the time."

Staff were knowledgeable about people's needs and some staff displayed a clear understanding of the impact that living with dementia had on people. For example, one staff member acknowledged what a person living with dementia was experiencing and validated their feelings by talking to them about the doll that they were holding and asking questions about their baby. The person became animated and smiled broadly at this acknowledgement of their reality. A second staff member was observed supporting a person who was showing signs of agitation and distress. They spoke to them gently and calmly, using eye contact and approaching them in a non- confrontational way, with open body language and a gentle touch to the arm. The person responded well to their approach and agreed to "Go off for a coffee break" with the member of staff. They were observed to be sitting calmly and happily with the staff member. The regional support manager had taken one person out in their car with the roof down because they knew that the person enjoyed this and it promoted their well-being. The person told us how much they had enjoyed this experience.

Staff spoke about improvements that had been made since the last inspection in February 2017. One staff member said, "We still have a long way to go but things are so much better. I can now go home and sleep knowing that people are being cared for."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 6, 7 and 15 February 2017 we found that people did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 there had been some improvements but there remained concerns about the lack of meaningful activities and stimulation for people and continued failures to update care records. This meant that there was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been assessed before coming to the home and their care plans guided staff on how to provide care to meet their needs. There was a comprehensive range of care plans in each person's records describing their assessed needs and providing a plan for staff to follow. Some aspects of the care plan included details of people's preferences and wishes regarding their care. For example, one nutritional care plan stated 'Likes tea with one spoon of sugar, dislikes alcohol.' Another psychological care plan stated, 'Enjoys gardening and likes to watch TV, particularly programmes about the Queen.' This detail ensured that staff had the information they needed to provide personalised care. However people's care plans were not always updated to ensure they reflected changes in people's needs.

Since the last inspection care plans were in the process of being reviewed for each person. A system was in place to focus on a 'resident of the day' to check that the care plan provided an accurate reflection of their needs. At the time of the inspection nine of twenty seven people's care plans had been updated since the last inspection in February. We looked at an updated care plan and found that assessments and care plans had been reviewed and identified actions were taken. For example, a capacity assessment had been updated and medicines that were given covertly had been reviewed with the GP to confirm that this remained the most appropriate and least restrictive method to support the person with their medicines. Best interest decisions were clearly documented and the medicines care plan had been updated to reflect this. Other care plans for the person were also up to date and accurately reflected the needs of the person. The regional support manager told us that staff were being supported with training on person, centred care planning to improve the quality of recording and to aid holistic care planning.

Although these improvements were positive they were described as a work in progress, and the remaining care records were yet to be updated. It therefore remained that some care plans failed to identify changes in people's needs or to give clear guidance to staff about how to support their needs. For example, one person was living with dementia and we observed that they were very anxious and confused, they were heard saying, "Oh my word I will have to pay for this – oh I don't like that – don't know what is going to happen about that." The person's care plan did not record anything about anxiety or confusion and did not provide guidance for staff in how to support the person.

Another person who was living with dementia had been refusing to take some of their medicines. Staff knew this was a regular occurrence however no action had been taken to review the person's medicines and decide if it was in the person's best interests to receive their medicines in a different way. This meant that the person was not receiving responsive care.

People who had been living on the top floor of the property had been relocated to the lower levels in the home to ensure that risks of isolation were reduced. Staff told us this had made a difference and they were able check on people more regularly. A system had been introduced to ensure that regular checks were made for people who spent extended periods of time in their bedrooms. Records confirmed that two hourly checks were happening and we observed staff checking on the welfare of people and having a brief chat with them.

On both days of the inspection it was apparent that there was a lack of organised activities and occupations for people. We found that some people were spending significant amounts of time in their bedrooms and had little stimulation throughout the day. Other people were spending time in the communal lounge areas or the dining rooms. There was piped music playing throughout the corridors of the home and in the main lounge the television was at a high volume. In the adjoining dining area the radio was left on for much of the day. The level of competing noise was not always conducive to a relaxing environment for people.

During the first day of the inspection we observed few interactions between staff and people other than when care needs were being attended to or food and drinks were being offered. During the afternoon there were seven people sitting in the main lounge area with the television on but nobody appeared to be watching the programme. Some people were sleeping in their chairs, others appeared to be withdrawn. A member of staff was present in the room but was making no attempt to interact with people unless they indicated that they needed something. When asked what was planned for the afternoon they said, "I don't think there's much going on. We haven't got any activity staff at the moment. " Later we observed one staff member spending time with one person, painting their nails. The person was clearly enjoying this and they were smiling and chatting happily to the staff member. Some people were spending time in the conservatory room and we saw a member of staff encouraging two people to take part in a board game. One person was able to go out and sit in the garden as it was a warm day and one person was taken for a car ride in the afternoon. Apart from these interactions we saw little evidence that people were being offered activities to stimulate interest and occupy them. Some people appeared to be bored and were showing signs of agitation. One person was persistently seeking out staff who were polite but dismissive of them. Eventually this person was offered a ride in a car as they appeared to be increasingly agitated.

During the morning of the second day of the inspection we observed that six people were sitting in the front lounge with the TV on. They were all asleep until staff arrived to serve mid- morning drinks and snacks. Once this had happened people all drifted back to sleep. We checked people's care records and could find no reason or explanation that might explain why people were so tired in the morning. We noticed that people were engaged and animated when staff offered them drinks but quickly went back to sleep when staff left. We discussed this with the Regional Support Manager who agreed that the most likely explanation was that people were sleeping because there was a lack of stimulation.

At the last inspection in February 2017 we had been told that an activities co-ordinator had been recruited. The new activities co-ordinator was due to start within the next week and that there were plans to introduce a second activities staff member. On the second day of the inspection we observed that the newly appointed activities co-ordinator and a volunteer were spending time talking to people individually. The provider had a standardised activities plan but this was yet to be implemented and there was no plan to implement the provider's activities plan and address the lack of occupation and activities. Some people were seen having hand and foot massages with a visiting beautician. This generated a lot of interaction with people and they appeared to be enjoying the experience. During the afternoon a singing group arrived to entertain people. Despite these positive events our observations were that for most of the day the majority of people had few opportunities for stimulation or occupation. People who were spending the day in their rooms remained at risk of social isolation and people were not being supported to have meaningful and

stimulating occupations during the day.

Some care plans included information about people's backgrounds, their interests and hobbies. For example, one person's care plan described their interest in nature programmes on TV. The person was not able to verbalise but we observed that staff had put on a wild life programme for them. A staff member told us, "It's really important that she has her hearing aids in and that they are working so she can listen to the TV as well." We observed that the person had both hearing aids in which appeared to be working and they were relaxed and enjoying the programme. However not all such information was being used consistently to effectively reduce risks of social isolation. For example, one person's care plan stated 'Sometimes feels isolated due to hearing difficulties, staff to be aware of her situation and spend time with (person's name).' The care plan goes on to state that the person should be encouraged to spend time in communal areas and to participate in activities. We did not see this happening and there was no guidance for staff in what sort of activities or interests would be most relevant and appropriate for this person.

Staff told us that they were worried that people were lonely and felt isolated. One staff member said, "I do worry that residents are lonely, especially those without a television." Another staff member said, " I definitely worry that people are lonely. At the end of the day we might get more time for one to one activities, we would record those interactions in people's journals but we don't always do that, this an on-going issue." A third staff member said, "When it is quieter we have time for activities, however I do feel people are lonely. We try and talk with them and I take one lady out in the garden but it depends how busy we are."

Recording in people's 'personal journals' was consistently poor and confirmed that people were not receiving stimulation and were at risk of social isolation. For example, one person's journal had only seven recorded events between January and May. Six of these entries referred to having enjoyed their lunch either in the dining room or in their own room. One entry refers to them spending time looking through a magazine. Staff told us that they often neglected to record entries in people's journals. This meant that there was a lack of evidence about how people's social needs were being met. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had a complaints system and kept records of each complaint received and actions taken to resolve the complaint. We noted that a letter had been written to a complainant that set out a clear response to each issue raised in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 6, 7 and 15 February 2017 we found that the registered manager and provider had not ensured that there were accurate and complete records that were stored securely. The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided, including the experiences of people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on 31 May and 7 June 2017 there had been some improvements in leadership and within the culture of the home but there remained concerns about the lack of effective governance systems.

The registered manager had left on 7 February 2017. Since then a manager, who is registered at another of the provider's homes, has been in charge of the day to day running of Bon Accord. A deputy manager was also transferred from another home to assist with improving systems.

Following the inspection of February 2017 the provider had developed an action plan to address the breaches of Regulations. This plan covered many but not all areas of practice that were found to be in breach of the Regulations. For example, the action plan lacked detail about how improvements would be made to ensure that people were treated with respect and dignity at all times and that people received person- centred care. There was also little detail about actions to improve effectiveness of governance systems. This showed that although attention had been focussed on improving some key areas of practice, clear management plans were not in place to address other breaches.

The acting manager and deputy manager had undertaken a root cause analysis to determine how to address the longstanding issues with managing medicines, identified in the inspection of February 2017. Improvements had been made and sustained but it could not be evidenced that the system for ensuring medicines were always available was robust and being monitored by the provider. This was because the system was reliant on one staff member and the acting manager. If they were both absent no other staff were trained to order medicines. The acting manager gave us assurances that other staff were due to be trained in the procedure for ordering and checking medicines but this had not yet happened. This meant that there was a continued potential risk that people's medicines may not always be available.

Governance arrangements were not always effective. A number of audits had taken place to identify shortcomings in practice, however action plans had not always been developed following these audits to ensure that measures were taken to make improvements. For example, the acting manager had undertaken medicine audits for the two months before the inspection, a pharmacist had also given advice. However actions to be taken had not been identified with a timescale for improvement. Although management of medicines had been a clear focus of the improvement plan for the home since the last inspection there remained a lack of management oversight with regard to the practice of some staff. There was a lack of care planning for some clinical needs such as wound care and diabetes care. This showed that clinical governance arrangements were not always being effectively monitored by the provider.

The regional support manager told us that "Medicine management has been the priority and now we are

focussing on care planning." They went on to tell us that there were governance systems in place to ensure that all care plans were updated and to check the quality of the information so that the acting manager could be assured of the accuracy of people's care records. However this system was not yet embedded and sustained and at the time of the inspection the majority of care plans were yet to be updated. We found that care plans sometimes lacked accuracy, monitoring continued to be inconsistent and risk assessments were not updated and reviewed. Information from health care professionals had not always been included in care plans.

Actions had not been taken to address all previously identified risks, for example people remained at risk of social isolation and there was a lack of meaningful activities available to support people to follow their interests. Although staff had been recruited to lead activities within the home they were not yet in post and no other plans had been made to take this work forward. We saw some examples of good practice but most staff were not clear about their role in reducing the impact of loneliness for people and we noted missed opportunities throughout the inspection where staff did not always engage with people. There was a lack of organisation, co-ordination and planning to address risks of social isolation. This meant that the provider's governance process was not always effective in being able to identify shortfalls in practices and implement the necessary action to address.

Lack of effective systems to monitor the safety of services provided and to mitigate risks, lack of accuracy in care records, lack of robust and effective systems to maintain quality and drive improvements meant that there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and staff told us that management at the home had improved since the last inspection. One person said, "It is much better, I think it is generally a well -run home." A relative said, "There have been a lot on improvements, it's much better and the atmosphere has improved." Another relative told us, "I feel a lot happier now, the staff are very good and I think it will be alright now the new manager is here."

Staff were also positive about the management. One staff member said, "With the new management and new nurses in post the atmosphere here has really improved." Another staff member said, "I am really enjoying it here since the new manager started." A third staff member said, "Morale has improved, it's a more relaxed atmosphere, I don't feel pressurised." One staff member told us, "Whereas there was no leadership before, now we have a strong manager who listens and acts." They spoke about the new manager saying, "She is very good, she listens and is so supportive, she gives a clear understanding of what is expected of us."

Staff told us that morale had improved. One staff member said, "Staff are coming back who had previously left, that is how much things have improved." Our observations confirmed that staff appeared to be happier and more positive about the home. Staff said that they felt comfortable to approach the acting manager with any concerns and spoke highly of the support that had been provided in recent months. One staff member said, "The manager is friendly, supportive and I feel comfortable talking to her." Another said, "The manager is open and honest about what is happening, where we are and what we still need to work on." A third staff member said, "I'm always in there asking questions, she's really approachable. I hope she never leaves. We are all much happier here now."

Leadership at the home had improved. Staff told us that they felt clearer about their roles and responsibilities. One staff member said, "We are now clear on what we have to do, there are clear guidelines to follow." Another staff member said, "It is better now because information is passed between the nurses

and us, it's much better, we have handovers and we know what we are doing."

The acting manager had arranged a meeting with people and their relatives to discuss the concerns arising from the last inspection and to talk about plans for making improvements. Throughout the inspection the acting manager and the regional support manager were open and honest about the challenges that they were facing in making improvements at the home. The area manager told us that the provider was committed to maintaining support for the acting manager. The regional support manager said that they expected to remain at the home for the foreseeable future. They said, "There is a lot of work to do and any improvements that we make need to be sustainable in the long run."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care It continued that the provider had not done everything reasonably practicable to make sure that service users received person - centred care and treatment that is appropriate meets their needs and reflects their personal preferences.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect It continued that service users were not treated with dignity and respect at all times when they were receiving care and treatment

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There remained an inconsistent approach to assessing people's capacity to consent to their care and treatment. Whilst some mental capacity assessments had been completed practice in this area was not embedded and sustained. Conditions of DoLS authorisations were not always met.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Continued failures in managing medicines and continued failure to assess and manage risks to people means that there remains a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance It continued that the provider had not ensured that there was effective governance. They had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity. They had not assessed, monitored nor mitigated risks relating to health and safety of people

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.