Care Quality Commission

Swinton Hall Nursing Home Limited

Swinton Hall Nursing Home Limited

Inspection report

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07 December 2017

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on 06 and 07 December 2017. This inspection was undertaken to ensure improvements had been made by the service following our last focussed inspection on 07 June 2017.

When we carried out a comprehensive inspection of Swinton Hall Nursing Home on 05 and 06 April 2017 we found the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance, and Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We then carried out a focussed inspection on 07 June 2017 and a pharmacist who is a medicines inspector with CQC visited the home to see if the necessary improvements had been made to ensure that people were protected from the risks associated with the safe handling of medicines. At that inspection we found continuing concerns regarding medicines management and the service was still in breach of this regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve. At this comprehensive inspection on 06 and 07 December 2017 we found medicines were still not being administered safely.

During this inspection, we also found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to receiving and acting on complaints, good governance, staffing, fit and proper persons employed. We are currently considering our enforcement options in relation to these breaches.

Swinton Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Swinton Hall Nursing Home is a privately owned nursing home and is within easy access to the cities of Salford and Manchester. The home is registered to provide accommodation with personal and nursing care for up to 62 people across two units. The home has a 15 bed continuing care unit to support people with complex nursing needs. At the time of the inspection there were 42 people using the service with 11 people residing in the continuing care unit, 18 people in the ground floor and upstairs nursing units and 13 people occupying residential beds.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not always handled or administered safely. Effective systems for the safe administration and storage of drink thickeners were not in place, which placed people at risk of harm. Records regarding the administration of moisturising or barrier creams were not always completed and this meant people's skin might not be cared for properly. Although medicines had been audited, these had failed to identify the continuing issues we found during the inspection regarding the unsafe management of medicines.

The provider had a process of staff recruitment in place but this was not consistently followed for every staff member. One staff member had been recently recruited but did not have a specific job role identified and references supplied were insufficient. The manager also confirmed this staff member had also not received any formal period of induction.

A staff vacancy of 'unit lead' in the main nursing unit of the home had not been replaced and attempts at recruiting to this role had been unsuccessful. The registered manager was unclear why this had happened, and how to ensure that it did not happen again. As a result the registered manager was engaged in clinical nursing activities which detracted from their ability to undertake the registered manager role.

The home had a management and staffing structure but not all job roles had been filled. This meant there was a lack of appropriately skilled staff deployed which resulted in the registered manager being unable to ensure effective oversight and governance, due to being involved in clinical tasks.

Building cleaning schedules were in place and the premises were clean and tidy and there were no malodours. Staff wore appropriate personal protective equipment (PPE) such as gloves and aprons as required.

The provider had failed to submit statutory notifications to CQC regarding applications/decisions for when a person was deprived of their liberty (DoL). Information received from a best interest assessor during the inspection indicated DoLS applications were not submitted in a timely way and information in applications submitted was poor.

People we spoke with and their visiting relatives agreed that staff were kind and compassionate and thought staff treated them with respect. However we observed people were left alone in the communal lounges on many occasions and this was particularly apparent when staff were engaged in supporting other people.

Some people's needs and care plans had been reviewed and updated but this was not consistent. This meant we could not be confident their needs and the risks associated with them had been identified and managed. It was not always possible to determine how often people needed support to change position as this was not detailed on all people's turning charts.

There was no clear identification of people with end of life care needs which meant they may not be supported in ways that reflected their current medical condition and personal preferences. This could result in insufficient care being provided which could undermine people's dignity and preferred choices.

The manager acknowledged the home had received complaints but these had not been recorded properly and therefore we could not determine the nature and number of any complaints received since February 2017 and if these had been responded to correctly.

The home has been rated as requires improvement since 2015 and the provider had failed to improve the overall rating of the home from 'requires improvement' over time. The expectation would be that following

the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'good' or 'outstanding' at this inspection. This had not been the case, as we found the quality of service provided to people living at the home was not continuously improving over time.

We identified significant shortfalls in the care provided to people at the home. This was linked to ineffective governance arrangements and leadership both by the provider, and through the management arrangements in place at the home. Audits were not up to date and day-to-day clinical and operational leadership of staff was inadequate. The provider had failed to provide sufficient oversight to recognise and respond to emerging issues identified at this inspection.

Shortly after the date of the inspection the provider contacted us to inform us they had taken the decision to close the home. Following this we attended a meeting with the provider, the clinical commissioning group (CCG) and local authority commissioners to identify the next course of actions and expectations of the service regarding the closure process. It was agreed a high level action plan would be drawn up by the provider to mitigate the risks identified at the inspection during the closure process.

Salford adult social care and Salford CCG made direct contact with all the people living at Swinton Hall and their families to identify wishes and needs and help find alternative suitable care home places. This took place in close co-operation with the owners of Swinton Hall to ensure the service continued whilst ensuring a smooth and safe transition for all the people living there. CQC also worked together with Salford local authority regarding the situation, in line with the joint national guidance on care home closures.

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.

Medicines were not administered safely.

Staff recruitment procedures had not been followed.

Agency staff were used regularly which affected continuity of care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Applications to deprive a person of their liberty were not always submitted in a timely way.

The service had not maintained accurate records of the decisions taken in relation to the care and treatment provided.

Gaps in care records meant we could not determine if all people had received sufficient nutrition and hydration.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

Staff respected people's privacy and dignity.

The home had policies on equality and diversity and anti-bullying and staff were aware of how to follow them.

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Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care did not always meet people's needs and reflect their preferences.

There was no clear identification of people with end of life care needs.

A complaints system was in place but was not up to date.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not understand their legal responsibilities in respect of submitting statutory notifications to CQC.

The service undertook a number of audits to monitor the quality of service provision but they were out of date and did not highlight some of the concerns we found during our inspection.

The service had not ensured the deployment of sufficiently qualified, competent, skilled and experienced persons.

Swinton Hall Nursing Home Limited

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 checked 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.

Prior to the inspection we received information from the local authority regarding a number of safeguarding referrals they were investigating. The information shared with CQC about these referrals indicated potential concerns about the management of people's nursing care needs. This inspection examined those risks.

The inspection was undertaken on 06 and 07 December 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors, a CQC pharmacist inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts were experienced in older adult's residential and community dementia care.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We reviewed statutory notifications and any safeguarding referrals previously submitted by the service.

We looked at records held by the service, including policies and procedures, staffing rotas and staff training records, ten medication administration records (MAR) six care files and six staff personnel files.

We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation. We observed care within the home throughout the day in the lounges and communal areas.

We observed the medicines round and the breakfast and lunchtime meal. We toured the premises and looked in various rooms. We also reviewed previous inspection reports and other information we held about the service.

At the time of the inspection there were 42 people using the service. During the inspection we spoke with the registered manager, seven care staff, twelve people who used the service, two relatives and one visiting healthcare professional.

Inadequate

Is the service safe?

Our findings

When we inspected the home on 28 April 2016, 12 July 2016 and 05 and 06 April 2017 we found continuing breaches in relation to the safe management of medicines at each inspection. At the last focussed inspection on 07 June 2017 a pharmacist who is a medicines inspector with CQC visited the home to see if the necessary improvements had been made to ensure that people were protected from the risks associated with the safe handling of medicines. At that inspection we found continuing concerns which meant the service was still in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medication administration records (MARs) for ten people. A large number of MARs were handwritten by staff of the home and (with two exceptions) only signed by one person, which could increase the potential for errors. Checking by a second nurse reduces the chance of a mistake and is good practice. The amount of medicine received from the pharmacy and any stock remaining from the previous month was not recorded on the MAR. This meant that medicines could not be accounted for by comparing the stock with the administration record.

We observed some people taking their medicines and saw that nurses administered medicines in a kind and appropriate way. We saw two medicines due at a specific time being given at the right time. However, two other medicines that needed to be given at exact times to protect people from harm were administered 55 and 100 minutes late. In one person's room we saw that two boxes of medicine had been left by the bed instead of being locked away. This meant other people were at risk of harm if they accessed medicines not intended for them.

One medicine for a particular person had been stopped by their doctor two days previously. This medicine was packed in a 'bubble pack' together with other tablets. We checked the home's disposal record and the back of the person's MAR but there was no record to confirm that this tablet had been identified and withheld when the person was given their other medicines. The prescribing pharmacy was only asked to re-pack the medicines and remove the tablet no longer prescribed when we brought the matter to the attention of the nurse on duty. There was a risk that this person could be given a medicine the doctor had discontinued.

Protocols (extra written guidelines) were in place for some people who were prescribed a medicine 'when required' (PRN). We looked at one person's protocol and found that it contained the necessary information for nurses to administer the medicine in the right way. Another person was prescribed a variable dose of a strong painkiller PRN. There was no protocol in place and nurses had not recorded the actual dose administered on the person's MAR. This person had also been taking a regular medicine for pain control. This medicine was out of stock and nurses had not requested a new prescription from the person's doctor.

The use of thickening agents to prepare drinks for people who had swallowing difficulties was not accurately documented. People prescribed thickening agents are at risk of choking if their drinks are not thickened to the right consistency. Some people were prescribed moisturising or barrier creams that were applied by

carers. We asked to see the records for one person who was prescribed these creams and staff could not find them. This meant people's skin might not be cared for properly.

Medicines were stored securely. The temperature inside the medicine storage room was below the maximum recommended by drug manufacturers. However, the home's records showed that the maximum temperature reached inside the medicine refrigerator was often above the upper limit of eight degrees Celsius. This meant that medicines in the fridge could be less effective or even unsafe to use.

Medicines that are controlled drugs (medicines subject to tighter controls because they are liable to misuse) were stored in a cupboard that complied with the law. The cupboard contained a large number of controlled drugs (CDs) that were no longer required. Reconciling the stock balance of CDs with the records was difficult because a number of CD registers were in use. Nurses did not carry out stock checks. This meant there was an increased risk of a mistake when CDs were administered. If CD's are poorly managed there is also a chance of mishandling or misuse. We asked the manager to ensure that a full stock check was completed before the end of the inspection. This was done and stock levels of CDs in use were entered in one register. We checked the stock balance of two CDs and they were correct.

This meant there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. The provider had failed to protect people against the risks associated with the unsafe use and management of medicines.

All of the people we spoke with told us they felt safe and there was no bullying by staff or other residents. One person gave a big smile and said, "It's good here." Another person said "Yes, it's all right; but I don't like anybody looking after me." The relative of this person added, "I like it here." A third person told us, "They [other people] don't bully, it never occurred to me that they might; if they did I suppose I'd talk to the staff or the manager." All but one person said they would talk to staff if they had concerns; they said, "I'd get my son, he comes often, he'd sort it out for me."

We asked people if they felt there were enough staff on duty to safely provide care. Most of the people we spoke with were reasonably sure that there were enough staff by day and night and that they wouldn't have to wait long if they pressed their nurse call-bell for assistance. One person said, "I think there are enough staff; they wouldn't be long in coming. I've got everything I need anyway." Another person said, "It seems all right."

One staff member commented, "We use agency staff and sometimes it's difficult at night." A second staff member said, "Staffing levels are usually okay unless someone is off sick." A third told us, "We get allocated different units within the home but it would be better if we stayed on one unit for continuity and because we know people; I'm not sure why that happens."

We found when determining the level of staff required to meet people's needs the service took into account people's needs and their dependency level, using a dependency level tool. This identified the level of staff assistance required for various tasks such as washing, dressing and mobilising. A copy was kept in each person's care file and was reviewed each month.

There were two nurses on duty during the day who were supported by nine care staff, domestic and kitchen staff and an activities coordinator. At night there were two nurses and five care staff. However the rotas that were provided to us contained a mix of typed and hand written information; some date had been crossed out and over-written making it difficult to easily determine who was on duty on some days.

We found the provider used agency nurses to cover any shortfalls. The manager explained that when reliant on agency nursing staff, they tried to use the same agency nurses to ensure continuity for people who used the service and this was confirmed by other staff members.

We reviewed a sample of six staff personnel files, including recruitment records, five of which demonstrated that staff had been safely and effectively recruited. The files included written application forms, a written record of the job interview, proof of identity, proof of address and at least two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

However one staff member had recently been recruited initially as a general assistant but there was no job description for this person in their file, which contained one page of a two page DBS check. There were two references for this staff member; one from a previous company that only confirmed employment dates and another reference from the registered manager of Swinton Hall. The registered manager was unable to identify what this person was actually employed to do; they said, "Well we don't really know; they started in the kitchen and then we thought their skills could be better used somewhere else and now they are helping me." Other staff we spoke with confirmed they did not know what job role this person was undertaking.

At the time of our inspection the registered manager had taken on an assistant without a clearly defined role or job description to support her. Staff we spoke with were unable to identify what the role of the registered manager's assistant was. One said, "[Staff name] role is variable, they started in the kitchen, then they were a senior and now it has been announced they will be the registered manager's personal assistant." Another staff member said, "It is not clear who's who or what their role is, they started in the kitchen but it didn't go well."

This meant there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed. The provider had not operated recruitment procedures effectively.

We checked to see how people living at the home were protected from abuse. Staff we spoke with were able to explain to us the principles of safeguarding and what action they would take if they had any concerns. We found that all staff had received training in safeguarding vulnerable adults, which we verified by looking at electronic training records. We also looked at the home's safeguarding policy and the local authority safeguarding policy that was available to all staff.

Care files contained personal emergency evacuation plans (PEEPs), which provided guidance on the support people required to vacate the premises in an emergency. We saw these had been reviewed monthly.

We saw people had risk assessments in their care plans in relation to areas including falls, nutrition, moving and handling, pressure sores, continence. Care files included an initial assessment and an environmental assessment to help ensure people's safety. We looked at how the service managed accidents and incidents. Appropriate up to date accident/incident policies were in place and accident/incident forms were completed correctly and included the action taken to resolve the issue and reduce the potential for repeated events. An accident/incident monitoring form was used and this recorded the date/time of the incident, the location, who the injured person was, the type of injury sustained, the circumstances of the incidents, and the date reported to CQC.

We looked at health and safety and building maintenance records to ensure the premises was safe. Building cleaning schedules were in place and these identified tasks to be carried out in various areas of the home;

records regarding cleaning were completed and up to date. Liquid soap and paper towels were provided in each of the toilets and bathrooms. There was instruction on appropriate hand washing techniques which helped to minimise the risk of cross infection within the home.

The premises were clean and tidy and there were no malodours. A recent infection control audit had been carried out by Salford City Council in October 2017 and the service had achieved an overall score of 88% compliance. A follow up infection control spot check was then undertaken in November 2017 and the home had made positive progress since the date of the previous check. However, there were a number of outstanding actions still to be completed such as the auditing of equipment to ensure it was clean and safe to use.

Staff wore appropriate personal protective equipment (PPE) such as gloves and aprons as required which would help prevent the spread of infections. All the people we spoke with told us they felt the home was always clean, however one person commented, "I'm not sure if they ask if it's all right to clean before they do it."

Requires Improvement

Is the service effective?

Our findings

We checked to see how the service ensured that staff had the required knowledge and skills to undertake their roles. We received mixed responses from people who used the service when we asked if staff knew what they were doing. Three people simply told us, "Yes." One person added, "They're all right." Another person said "I think so, but I've not been here long." The relative of this person, (who visited every day) added, "Yes, but we don't really see enough to tell when we're visiting; they did notice [my relative] wasn't eating and had stomach problems, so they called me and they called an ambulance; it's the result of a medical condition and will probably happen again." In contrast all of the people we spoke with were sure the staff would call a doctor if they said they didn't feel well and would let their families know so they could be there when the doctor came.

We looked at staff training records, which included details of training previously undertaken and dates for when training was due for renewal. We saw staff had undertaken training in a number of areas including dementia, safe administration of medicines, food hygiene, record keeping, mental capacity act (MCA), safeguarding, moving and handling, fire evacuation, health and safety, COSHH and infection control.

We looked at staff personnel files. Newly recruited staff followed a formal induction programme and undertook a range of basic mandatory training. An induction checklist was completed for each new staff member and this was used until the staff member was deemed competent. Induction records also identified training staff had undertaken. However one recently recruited member of staff had not received an induction and the manager told us there had been no induction done for this staff member.

The staff we spoke with confirmed they received supervision, which we verified by looking at supervision records. A supervision tracker was used and we found staff received supervision every three months. Records of meetings were kept and signed by the manager and supervisee. We saw discussions included paperwork, storage of creams, nutrition, the use of equipment and chemicals, maintenance issues. If any actions were required, these were identified. Supervisions enable managers to assess the development needs of their staff and to address training and personal needs in a timely manner.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA/DoLS require providers to submit applications to a 'supervisory body' for authority to do so and we saw that the service had previously made the applications for several people to the local authority. However there was no on-going record held by the manager which would enable the process of applications to be monitored effectively and processed in a timely way.

If a provider makes an application to deprive a person of their liberty they are required to send CQC a statutory notification when the outcome of the application is known. We checked the provider's notifications file and saw no notifications had been sent to CQC regarding DoLS which we also verified by checking our own records. The provider had therefore failed to notify CQC as required. We spoke with the registered manager about this and they said they did not know about this requirement but would make sure notifications were sent to CQC in future.

We also spoke with a visiting Best Interest assessor from the local authority who was undertaking a best interest assessment for one person. They told us, "Referrals are sent at the last minute and the manager is not available when I call. I have concerns that referrals are not always sent when they should be and the quality of the information in DoLS referrals forms could be better.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person.

We observed the mealtime experience at breakfast and lunch. Breakfast was a choice of hot or cold options and we saw snacks and drinks were offered throughout the day. There was a food hygiene policy and staff had completed training in food hygiene. There was a four week rolling menu which was posted on the wall of the dining room and was in pictorial format which would assist some people to recognise the meal on offer.

The kitchen was clean and fridges, freezers and cupboards were adequately stocked with food. There were plenty of frozen and tinned provisions as well as dry goods, fresh food and fruit. In the morning we saw staff explaining to people what was for lunch. At the lunchtime meal there was a relaxed unrushed atmosphere and we saw that staff interacted with people in a respectful and dignified manner, encouraging their engagement. Staff provided assistance to people who required it and spoke politely to people confirming with them what they wanted to eat and drink before serving it. At an audit carried out in May 2017 the service achieved an overall food hygiene rating score (FHRS) of five. FHRS score ratings based on how hygienic and well-managed food preparation areas are on the premises.

Information on special diets was displayed in the kitchen and there was also guidance around special diet types. We saw evidence of diet and fluid charts for people who required monitoring in these areas, however not all entries on records had a date identified making it difficult to ascertain exactly what people had eaten each day and if they had received sufficient nutrition and hydration.

We also saw an entry in notes of a previous staff meeting that stated: 'All units to take residents to table for meals; only see staff sat at table; aware some won't use dining room; want a list of residents who won't.' This instruction, could lead to people's individual preferences regarding where to eat meals not being taken into account.

We found there were people living at Swinton Hall who were living with dementia. We saw people's bedroom doors had their photo and room number on it which would assist some people to orientate to their room. There was signage throughout the home identifying different areas such as the dining room and

bathrooms/toilets which would assist some people to orientate around the building. However there were still improvements that could be made to further improve the environment for people living with dementia such as the use of plainly patterned carpets and wall coverings. We observed there were several sets of fairy lights throughout the communal areas set to 'flashing' mode. Although these lights helped to celebrate and recognise the Christmas festivities they may have caused discomfort for people with dementia or other photo sensitive conditions.

Good

Is the service caring?

Our findings

People we spoke with and their visiting relatives agreed that staff were kind and compassionate. We observed staff respected each individual when providing assistance and took pride assisting people with their personal appearance. All people we saw were dressed appropriately and looked well-presented and everyone said their relatives and guests could visit them any time.

Most of the people we spoke with thought staff treated them with respect but were less sure about whether staff listened to them and did what they were asked. One person said, "They listen sometimes but don't always do what I say." Another person told us he preferred to be called by his middle name and staff always respected this. One person said "They [staff] usually do what I ask."

We observed staff interacting with people throughout the day and assisting them with personal care. Staff had an individual knowledge of people they were supporting and were responsive to their requests for assistance, for example we saw one person was supported to transfer safely and return to the lounge, at their request. Another person was assisted to sit outside and we observed a member of staff monitored the time this person was outside and prompted them to come back inside after a short while to keep warm. We observed another person requested a blanket to keep them warm and this was immediately provided.

During the inspection we observed staff members to be kind, patient and caring whilst delivering care. The home had policies on equality and diversity and anti-bullying and staff were aware of these policies and how to follow them.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through the process of person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different cultural groups received the appropriate help and support they needed to lead fulfilling lives and meet their individual and cultural needs.

We saw people chatting to staff and enjoying each other's company. We saw instances where staff took the time to speak to people and enquire about their welfare or inform them of what was going on. Despite this, throughout the inspection we observed people were left alone in the communal lounges with little oversight to maintain their safety or respond to their needs and this was particularly apparent when staff were engaged in other duties and supporting other people.

Everyone said staff respected their privacy and dignity which we observed, for example when we asked a staff member to attend to the person we were speaking with in their bedroom, two staff came quickly and asked us politely to leave the room while they assisted the person; they closed the bedroom door and informed us as soon as they had finished.

Everyone we spoke with thought staff did their best to help them retain independence. One person said, "Help me? Yes, I think they do." Another person told us, "Yes, they let you do things; I can wash myself."

Another person said the home had helped them to maintain a link to their family and that staff assisted them to get ready for their visits to their family member in the local area. A third person commented, "Staff are always popping in; I don't need to use the call bell."

People told us they were involved in care planning. One person told us they took part in all discussions about their care and health needs and would expect no less. They also told us [their relative] was also involved.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said they could make everyday choices such as when they got up or went to bed. One person said, "I get up or stay in bed as I wish; I go to bed when I want. I decide what I wear myself; I can wash and dress myself." Another person told us, "I wouldn't think they'd let me stay in bed," although this person was still in bed at the time we spoke. A third person said, "I choose my clothes but I have help to dress; they're very good at it." No-one we spoke with felt they had any restrictions. One person commented, "I could go out in the garden if I wanted." Another person said "I have to stay in bed, I can go in a chair and I've done that a couple of times."

We saw some people were receiving care that was personalised and responsive to their individual needs. Some people had a pre-admission assessment and their care and support needs had been identified with involvement from the person and their relatives. We saw details of how best to support someone if they were feeling upset and some people's spiritual and cultural needs were considered and reflected in their care plans.

However we saw not all people received care that was personalised and responsive to their individual needs. One person's pre-admission assessment related to a respite visit but they had been in permanent residence for over three months. This change had not been reflected in their care plan and the section relating to risk assessments was incomplete. This meant we could not be confident their needs and the risks associated with them had been identified and managed.

We saw some people's needs and care plans had been reviewed and updated but this was not consistent. The home used a paper based care planning and monitoring system. We looked at the monitoring charts for four people, these were filled in by night staff and included information about; fluid intake, dietary intake, pressure care, turning, oral hygiene, daily personal care and continence care. The night staff on duty reported they filled these charts in throughout the night. However, when we checked we found there were gaps in these records. One person had only two position changes recorded in the night at midnight and again two hours later and this was contradictory to their care plan information. Another person's charts indicated they had received support to reposition on two occasions but then nothing was recorded for the following five hours.

It was therefore not always possible to determine how often people needed support to change position as this was not detailed on the turning charts we saw. This meant that we could not be confident that people were receiving the support they needed to maintain good pressure care and as a result may be at risk of pressure injuries.

These issues meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user.

We looked at how the home managed complaints and saw the home had a complaints file. There was

evidence the home had recorded previous complaints and responded to them appropriately but a log of complaints had not been kept up to date. The most recent complaint recorded was from February 2017 and the manager acknowledged they had received other complaints since then but these had not been recorded properly. This meant we could not determine the nature and number of any complaints received since February 2017 and if these had been responded to correctly.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints. The provider had failed to establish and operate an accessible system for receiving, recording, handling and responding to complaints.

We asked staff about their understanding of person centred care and how they knew what was important to people. One said, "I take time to get to know people, read files and talk to others. I speak with people calmly, in private and ensure I offer choices." Another said, "When I write care plans I involve them by getting to know them and their background, I talk to families, seek other opinions." A third staff member said, "If someone is resisting, because they lack capacity, I talk with them, try to engage them and encourage them."

We looked at how the home supported people who were at the end of life. We were told there was no-one currently living at the home with end of life needs. The inspectors, together with the agency nurse identified at least one person who would be considered to have end of life needs. The pharmacist in the inspection team had also identified there were anticipatory medications in the controlled drugs cabinet. There was no clear identification of people with end of life care needs which meant they may not be supported in ways that reflected their current medical condition and personal preferences. This could result in insufficient care being provided which could undermine people's dignity and preferred choices.

We looked at the activities available for people in the home. We saw in some people's care plans there were details about their individual interests such as previous hobbies and experiences, favourite television programmes and books. Most of the people we spoke with said they no longer pursued their interests but instead watched television or were visited by their family. The home employed an activities co-ordinator but they were not in work at the time of the inspection. There was a creativity room available but this was not accessible and was being used for storage, which reduced opportunities for people to be involved in meaningful activities.

One person we spoke with said they were bored, however we saw staff did encourage this person to take part in a drawing activity with another person. Another person said they had been painting and making Christmas decorations. We did not see a schedule of activities for the person to help plan their week. A notice board near to the front door held some information about local events.

During the inspection a local school visited to sing Christmas carols. This had been organised by the home and people appeared to enjoy this activity. Other festive activities were also planned such as a party. One person confirmed the carol concert was, "A really nice thing to do."

The people we spoke with reported feeling able to raise any concerns they had and were confident action would be taken. One person said, "I would raise any concerns I have; I used to be quiet but I'm not now." Feedback forms were also available in the reception area.

We looked at the compliments the home had received; there were several 'Thank You' cards which we looked at. One of the cards stated, "Thank you for all the care and dedication shown to our mother." Another said, "Thank you for all your support, I will miss your friendship and will never forget our years together." A third stated "A special thanks to your activity coordinator and care staff for the enjoyable baking session."

The home had also sought people's opinions about the service and had undertaken surveys with residents, their families and staff. Information received from these was translated into a 'You Said – We Did' bulletin which was posted on a notice board in the entrance area. Comments included, 'We don't know what's for lunch – Menu displayed to everyone,' 'Wheelchair access was difficult due to narrow path – pathway widened.'

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The home has been rated as 'requires improvement' since 2015. Therefore the provider had failed to improve the overall rating of the home from 'requires improvement' over time. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'good' or 'outstanding' at this inspection. This had not been the case, as we found the quality of service provided to people living at the home was not continuously improving over time.

The home had a management and staffing structure but not all job roles had been filled. The registered manager reported having to spend half their time fulfilling this role. The registered manager reported having appointed three different people into this role but these people did not stay, with one staying for only two weeks. The registered manager showed a lack of insight into the difficulties recruiting into this role and reported feeling unsupported by the provider and the staff team.

The registered manager told us they had not replaced the staff vacancy for a 'unit lead' in the main nursing unit of the home because this "had not worked" on the last three occasions when someone had been recruited to the role. The registered manager told us the people recruited were not willing to fulfil the job role and had refused to complete some tasks; the most recent person had only stayed for two weeks. The registered manager did not have a clear understanding of why this had happened, and how to ensure that it did not happen again. This resulted in the registered manager engaging in clinical nursing activities which detracted from their ability to undertake the registered manager role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. The provider had not ensured the deployment of sufficiently qualified, competent, skilled and experienced persons.

Staff meetings were not held regularly and the last meeting minutes made available to us were from August 2017, written in note form and there was no evidence to indicate staff had seen them, for example a signing sheet to acknowledge having read them. Some of the areas covered included job roles, cleaning, mealtimes, incontinence pads, rotas and supporting people to eat.

Some of the staff we spoke with felt the registered manager was not always approachable or visible in the home. One staff member said, "The door is always shut, they are always in their office." Another said, "If I feel things need to change I advise staff, if they don't follow the advice there is no back up from the registered manager, they say they are too busy." Not all the people we spoke with were able to identify the registered manager. When asked who the manager was one person said, "I'm not sure." Another person

said, "I don't know; I don't know who it is."

We looked at how the home sought to improve and found that the registered manager felt unable to clearly identify what was needed or how to prioritise this. Previous strategies to monitor and maintain improvement which had been effective had not been continued. For example, there had been a daily manager's report but this had stopped in March 2017. This meant there was a risk that the governance of the home could deteriorate further.

We looked at the audits the registered manager and provider had undertaken of key areas of care and record keeping and found these were not up to date. The registered manager told us they were aware they had not been monitoring the service and auditing had not been completed. The most recent audits of care plans had been completed in March 2017, medication in March 2017, meal times in January 2017, and infection control also in January 2017 with one spot check in November 2017. Day-to-day clinical and operational leadership of staff was inadequate and the provider had failed to provide sufficient oversight to recognise and respond to emerging issues identified at this inspection.

The registered manager expressed feeling overwhelmed by the role and consequently was not able to provide effective leadership and management.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providers must ensure that their audit and governance systems remain effective.

We looked at the most recent resident and relatives' meeting minutes available from 09 August 2017. These covered: staffing changes and levels; use of agency staff; lack of seniors; the most recent CQC report; and activities and decoration. This showed the home was consulting with people about their concerns. The people we spoke with felt able to approach staff with any concerns and felt listened to. Although there were no regular meetings or surveys people said they felt able to raise issues as regularly as they wished.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12(1)

The enforcement action we took:

We had agreed a Notice of Proposal to cancel the provider and a Notice of Proposal to cancel the registered manager. Following discussion with the Nominated Individual the provider wrote to inform us they have taken a business decision to close the home. This is not only because of our findings but also as a result of economy pressures and difficulty recruiting qualified staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate an accessible system for receiving, recording, handling and responding to complaints. Regulation 16(2)

The enforcement action we took:

We had agreed a Notice of Proposal to cancel the provider and a Notice of Proposal to cancel the registered manager. Following discussion with the Nominated Individual the provider wrote to inform us they have taken a business decision to close the home. This is not only because of our findings but also as a result of economy pressures and difficulty recruiting qualified staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person. Regulation 17(2)(c) The provider had failed to ensure that their audit and governance systems remained effective. Regulation 17 (1) The provider had failed to establish effective

	systems and processes. Regulation 17(1)

The enforcement action we took:

We had agreed a Notice of Proposal to cancel the provider and a Notice of Proposal to cancel the registered manager. Following discussion with the Nominated Individual the provider wrote to inform us they have taken a business decision to close the home. This is not only because of our findings but also as a result of economy pressures and difficulty recruiting qualified staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not operated recruitment procedures effectively. Regulation 19(2)

The enforcement action we took:

We had agreed a Notice of Proposal to cancel the provider and a Notice of Proposal to cancel the registered manager. Following discussion with the Nominated Individual the provider wrote to inform us they have taken a business decision to close the home. This is not only because of our findings but also as a result of economy pressures and difficulty recruiting qualified staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured the deployment of sufficiently qualified, competent, skilled and experienced persons. Regulation 18(1)

The enforcement action we took:

We had agreed a Notice of Proposal to cancel the provider and a Notice of Proposal to cancel the registered manager. Following discussion with the Nominated Individual the provider wrote to inform us they have taken a business decision to close the home. This is not only because of our findings but also as a result of economy pressures and difficulty recruiting qualified staff.