Lakeglide Limited

Ersham House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Ersham House Nursing Home on the 27 and 28 February 2017 and the inspection was unannounced. Ersham House Nursing Home provides care and support for up to 40 people who have nursing needs, including poor mobility or diabetes, as well as those living with various stages of dementia. The service also had a contract with the local authority to provide care and support for up to seven people to prevent unnecessary hospital admissions. There were 27 people living at the service on the days of our inspection.

An acting manager was in post but they were not the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The previous registered manager left the service at the end of October 2017 but they had not yet submitted an application to CQC to de-register. The acting manager had been in post four months at the time of the inspection and told us they would submit an application to become the registered manager.

At the last inspection undertaken on the 4 and 5 May 2016, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to the principles of the Mental Capacity Act 2005 not being adhered to. Accurate and complete records had not been maintained and the management of medicines was not safe. The provider sent us an action plan stating they would have addressed all of these concerns by October 2016. At this inspection we found the provider had made improvements to the management of people's medicines. However, improvements were not yet fully embedded and the provider continued to breach the regulations relating to the other areas.

The principles of the Mental Capacity Act (MCA) 2005 were still not consistently applied in practice. Bed rail risk assessments were not consistently in place and people's capacity to consent to the use of bed rails had not consistently been assessed. Care plans were at times contradictory and failed to document and underpin whether people could consent to their care plans.

People spoke highly of the food provided and a nutritional champion was in post. Menus were devised in partnership with people and initiatives had been implemented to promote nutritional intake. However, where there was the risk of dehydration, improvements were required to the monitoring and oversight of people's hydration needs. We have made a recommendation for improvement.

The risk of social isolation had not consistently been mitigated. The registered provider had failed to maintain accurate, complete and contemporaneous records. People's monitoring charts were incomplete and included unexplained gaps and omissions. Incidents and accidents were not consistently audited for emerging trends, themes or patterns. The management of diabetes was not consistently safe and prescribed fluid thickener had been left in easy reach of people which posed a risk.

People received their medicines on time and in a safe manner. However, documentation failed to confirm when people's percutaneous endoscopic gastrostomy (PEG) tubes were last rotated. People felt staffing levels were insufficient and commented that staff presented as busy and the call bell was continually ringing. We have made a recommendation for improvement.

The management team were dedicated to the on-going improvements of Ersham House Nursing Home. A quality assurance framework was in place but the positive improvements were still in the process of being embedded and implemented.

People's individual ability to evacuate the service has been assessed and evacuation plans were in place. However, people's evacuation plans failed to highlight that the service would operate a 'stay put' policy at night. We have made a recommendation for improvement.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate application to restrict people's freedom had been submitted.

People told us they felt safe living at Ersham House Nursing Home and spoke highly of the staff. One person told us, "The staff are lovely and we have a laugh." Another person told us, "The staff are ever so kind."

People had access to relevant healthcare professionals to maintain good health. Records confirmed that external healthcare professionals had been consulted to ensure that people were supported to receive effective nursing care. People received good health care to maintain their health and well-being.

Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People were protected, as far as possible, by a safe recruitment system.

A range of group activities took place which people spoke highly of. One person told us, "We play dominoes, bingo and we're going to the cinema in a couple of days." People, relatives and staff spoke highly of the new management team. One staff member told us, "The new manager is ever so supportive and approachable."

During our inspection we found a number of 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?

Requires Improvement

Ersham House Nursing Home was not consistently safe.

The management of diabetes was not consistently safe and risks to people's safety were not always mitigated.

People felt staffing levels could be improved. People received their medicines on time; however, documentation failed to record and evidence when people's percutaneous endoscopic gastrostomy (PEG) tube was last rotated.

Appropriate checks where undertaken to ensure suitable staff were employed to work at the service. Staff were aware of how to recognise the signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

Ersham House Nursing Home was not consistently effective.

The principles of the Mental Capacity Act (MCA) were not consistently applied in practice.

People spoke highly of the food provided; however, improvements were required to the monitoring and oversight of people's hydration needs.

Staff recognised that people's healthcare needs could change rapidly and mechanisms were in place to maintain people's health and wellbeing

Is the service caring?

Good

Ersham House Nursing Home was caring.

People told us they found the staff caring, friendly and helpful and they liked living at Ersham House Nursing Home.

Staff were careful to protect people's privacy and dignity and people told us they were treated with dignity and respect.

People's information was treated confidentially. Personal

records were stored securely

Is the service responsive?

Requires Improvement

Ersham House Nursing Home was not consistently responsive.

A variety of activities were on offer for people within the home, but these activities did not always meet people's needs in relation to their past hobbies and interests. The risk of social isolation had not consistently been mitigated.

People's needs had been assessed and care plans were in place. People felt able to raise any concerns and acknowledged that these concerns would be listened too.

Is the service well-led?

Inadequate

Ersham House Nursing Home was not well-led.

Accurate, complete and contemporaneous records had not been maintained. The provider's internal quality assurance framework was not consistently robust. Further work was required to embed and sustain positive changes.

Further work was required to embed a person centred culture.

People spoke highly of the new management team in post and their leadership style. Staff said they enjoyed working at the service.

Ersham House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 27 and 28 February 2017 and was unannounced. The inspection was carried out by two inspectors and a specialist nurse advisor.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service: this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we spoke with nine people and two visiting relatives. We spoke with various staff that included the acting manager, the deputy manager, activities coordinators, chef, provider (owner), three registered nurses and four care staff. 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 experience of people who could not talk with us.

We looked at eight care plans and associated risk assessments, 10 staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person received and obtained their views. It was an important part of our inspection,

as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Ersham House Nursing Home on the 4 and 5 May 2016 where it was rated 'Requires Improvement.'

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Ersham House Nursing Home. One person told us, "I would say I feel safe here. I can't be at home as I can't work, but I like it here and I'm safe here." Another person told us, "Crikey yes, I am definitely safe here." A third person told us, "You know you are secure here, nobody will bully you and staff help us." Despite people's praise, we found elements of care which were not consistently safe.

At our last inspection in May 2016, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the management of medicines was not safe. The medicine trolley was left in the corridor open and unattended by staff whilst they gave medicine to people in their rooms. When medicines had been refused at teatime, these were left on top of the trolley while the staff gave medicines to another person. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2016. At this inspection, we found improvements had been made to the management of medicines.

During the inspection, we observed good practice when supporting people to take their medicines, the medicine trolley was never left unattended and when supporting people the registered nurses would lock the medicine trolley, therefore never leaving it open or unattended. Medicines were stored, administered, recorded and disposed of safely. Each person had an individual medication administration record (MAR) in place which included a list of any allergies, their GP and how they liked to received their medicines. MAR charts were subject to regular audits and we found MAR charts were completed correctly with no unexplained gaps or omissions. Medicines were labelled, dated on opening and stored tidily within the trolley. Medicine fridge and medicine room temperatures were monitored daily to ensure they remained within safe levels. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of following safe procedures.

Where people were administered homely remedies (such as paracetamol), a homely remedy policy was in place for nursing staff to follow and staff recorded when people had been administered paracetamol. However, documentation did not always record the date and quantity of when nursing staff administered homely remedies (such as paracetamol). Although no harm had occurred to people, this posed the risk that people could be administered over the maximum dosage of paracetamol in one day, as documentation did not consistently reflect when the pain relief was administered, time or quantity.

We recommend the provider reviews their internal homely remedy procedure.

The management of people's percutaneous endoscopic gastrostomy (PEG) tube was not consistently safe. The PEG was subject to regular flushes and clear guidelines were in place for staff to follow. However, the care plan for one person with a PEG tube advised that the PEG site was required to be rotated weekly and documented on the MAR chart. We checked the MAR chart and found it was not recorded on there. We subsequently queried with nursing staff where the weekly rotation would be recorded. They acknowledged this was not being recorded to evidence when it had been rotated. One member of the nursing team told us,

"I know that it was rotated last week by another nurse, but yes, this wasn't recorded." For new nursing staff, or agency staff, this posed a risk as they would not have the information available to confirm when the PEG was last rotated.

The management of diabetes was not always consistently safe. People living with diabetes have an increased risk of disability, pressure ulcer development and hospital re-admission. Diabetic risk assessments were in place; however, these failed to provide sufficient guidance on the signs of high and low blood sugar and what to do in either event. The diabetic risk assessment also failed to consider the management of foot-care and eye care. For people living with diabetes, foot care will be vital as they are at risk of peripheral neuropathy (loss of sensation in the feet). Risk assessments failed to provide guidance on the signs to look for and what action should be taken. One person's diabetic risk assessment advised, 'They are diagnosed with type two diabetes. They are on diet and daily insulin. To check their blood glucose before breakfast and when necessary. To give them insulin if blood glucose is more than five– seven mmol.' Where their blood glucose levels were low, we saw that nursing staff were taking action by administering glycogen. However, we were unable to see how they were following up on this, for example by providing a long acting carbohydrate such as a sandwich. We were also unable to see how they were following up on high blood sugar readings. We brought these concerns to the attention of the acting manager who was open and responsive to our concerns and agreed that all diabetic risk assessments required reviewing.

During the inspection we saw on two occasions, prescribed fluid thickener left in easy reach of people. Fluid thickener is used to help people who have difficulty swallowing. On one occasion, we found it was left in a person's bedroom on the bedside cabinet which was next to them. On another occasion, we found it had been left unattended in the communal lounge. This meant it was easily accessible for people to pick up. Prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. The management team were aware of this patient safety alert and confirmed fluid thickener should also be stored away in a secure location.

Failure to provide safe care and treatment of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels consisted of seven care workers in the morning and six care workers in the afternoon. Two registered nurses worked throughout the day along with one at night and three care workers at night. The acting manager told us, "We operate a ratio of one care worker to three or four 'residents.' We look at what's happening and consider people's level of dependency. Although we have a dependency tool in place, this probably isn't utilised as actively as it should be. But we base staffing levels on people's needs and feedback from staff." The service had a number of staff vacancies and was recruiting to those vacancies; however, in the interim the service was using a high level of agency staff. The acting manager told us, "We use the same agency staff so people and other staff get to know them." People confirmed that they saw a lot of different staff but told us that all staff were nice. One person told us, "Staff vary quite a bit but they are all nice." Another person told us, "They are lovely but I do see different faces."

Throughout the inspection, we observed that the call bell system was ringing constantly. One person told us, "I don't think there is enough staff. The call bell is always ringing and staff are ever so busy." Another person told us, "There is not enough staff. They are all lovely, but you have to wait when you press your call bell. When you're desperate for the toilet it can be a long wait and sometimes it is too late. Sometimes they do get here in time. They just seem very busy." A third person told us, "That call bell is ringing from morning to night." We found this was consistent feedback from the people we spoke with. People commented that they found the call bells rather frustrating but felt their needs were met. One person told us, "I can get up

when I want and go to bed when I want. Although it can take a while for staff to answer the call bell, they come when they can or they will come along and say they will be here in a minute." Staff members felt the mornings could be busy and acknowledged that not having their own staff team had an impact. One staff member told us, "There is a high use of agency staff and it would be nice to have our own team." Another staff member told us, "I think there should be another member of staff in the afternoon." We brought these concerns to the attention of the acting manager who recognised the impact of the call bell system continually ringing provided an impression to people that staff were continually busy. The acting manager told us, "We have been discussing with staff, what prevents them from answering call bells and they advised that in some parts of the building, they can't always hear the call bell. For example, when in a person's bedroom with the door closed. We have decided to move one call bell panel to see if that helps. If so, we move another one as well." The management team were aware of the concerns and taking action. However, people commented that the impacts of the call bells made them feel staffing levels were not sufficient and staff continually appeared to be busy. We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance on the safe deployment of staff and regularly consults people on their views of staffing levels.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses and regular re-positioning. Where people had open wounds, robust wound care plans were in place. Input from the tissue viability nurse (TVN) had been sourced and dressings were changed in line with the documented frequency required.

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. One staff member told us, "Any concerns, or if I witnessed bad practice, I would report my concerns to the nurse on duty or the management team." Safeguarding policies and procedures were in place for staff to readily access.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Where staff had commenced work before their DBS check being received, a robust risk assessment had been completed which assessed their competency and calibre. They also did not work unsupervised until their DBS had been received. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Moving and handling equipment was checked to ensure it was safe to use and fire-fighting equipment was subject to a regular health and safety check. People's individual ability to evacuate the building had been assessed and personal evacuation plans were in place. During the inspection, we identified a minimum of 16 people who would require assistance of two staff to evacuate the building. Staffing levels at night consisted of one registered nurse and three care staff. At night there were only four members of staff which would prevent a safe evacuation at night. We discussed these concerns with the

acting manager who confirmed they would operate a 'stay put' policy at night. Although a 'stay put' policy was in place at night, this was not reflected on people's individual evacuation plans.

We recommend that the provider reviews their internal fire safety procedures at night.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke highly of staff and felt staff were skilled and confident. One person told us, "The staff are very good; they know what they are doing." Another person told us, "I would say they are very skilled." A third person told us, "The staff are very good." Despite people's positive comments, we found areas of care which were not consistently effective.

At our last inspection in May 2016, the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the requirements of the Mental Capacity Act 2005 (MCA) were not embedded into practice. An action plan had been submitted by the provider detailing how they would meet the legal requirements. At this inspection, improvements were in the process of being made; however, these were not yet embedded in practice.

People's rights were not always protected because the provider did not always act in accordance with the MCA 2005. The MCA 2005 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. Not all staff had received training on the MCA 2005. The acting manager confirmed that training had been organised for the end of March 2017. This was confirmed by staff. Therefore staff's knowledge of the principles MCA 2005 was limited. However, staff recognised the importance of gaining consent from people and we observed this throughout the inspection. Nursing staff were able to clearly advise how they completed mental capacity assessments. One member of the nursing team told us, "We go through the four questions and consider if the person can understand, retain, weigh up and communicate. I did an assessment of whether a person could consent to living here. I asked them about living here and returned to the question a couple of minutes later and they had retained the information. I felt they had capacity for that decision." Mental capacity assessments had been completed for the decision whether people could decide about living at the service. However, for other specific decisions, mental capacity assessments had not been consistently completed. For example, where people had bed rails in place. We identified two people who had bed rails in place but with no bumpers. Failure to have bed bumpers in place, poses the risk of people getting a limb or their head caught between the rails. A bed rails risk assessment had not been completed and there was no rationale as to whether they consented to the bed rails or why the bed rails were required.

Some care plans contained contradictory information about people's capacity to make specific decisions. For example, one's person care plan identified, '(person) is unable to sign but has given verbal agreement to their care plan.' However, their dementia care plan noted, '[person] lacks capacity to make decisions over their health, welfare and financial matters.' There was no underpinning mental capacity assessment to confirm that the individual lacked capacity (or had capacity) to make decisions over their health, welfare and financial matters. Another person's care plan included a mental capacity risk assessment which documented they lacked capacity. However, under the MCA 2005, an individual cannot lack general capacity; they can only lack capacity for a specific decision.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Training records confirmed not all staff had received training on DoLS and this was confirmed by staff. The management team confirmed training was in the process of being organised but this may take some time as they were accessing local authority training and this meant not all staff could receive the training at the same time. Staff's understanding of DoLS was limited and staff were unaware of one person whose DoLS application had been authorised.

We brought these concerns to the attention of the management team who were open and responsive to our concerns and agreed that some paperwork required updating. Although improvements were in the process of being made and some decision specific mental capacity assessments were in place. These changes were not yet embedded or sustained and capacity assessments were not consistently in place for specific decisions. Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating. With permission, we joined people at lunchtime. The table was neatly displayed with flower arrangements, condiments and napkins. The menu was on display and people were given two options or any alternatives. People spoke highly of the food. One person told us, "The food is very good. We always get asked what we want and can ask for alternatives if there's nothing we fancy." Another person told us, "The food was lovely today." Where required, staff supported people to eat and drink and adapted cutlery and plate-guards were also provided to enable people to eat independently. The menu was devised with input from people and changed every four weeks based on people's suggestions. A nutrition lead was in post that completed a nutritional audit and monitored people's weight on a weekly basis. Regular meetings took place between the chef, acting manager and nutritional lead to discuss people who were losing weight and what action could be taken. A recent initiative included the implementation of a smoothie and milkshake round to promote nutritional intake. Where people required a soft or pureed diet this was provided and food and fluid charts were in place to monitor people's nutritional and hydration intake. A range of good practice was taking place. However, we observed an area of care which required improvement.

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. One person had recently returned from hospital after being treated for dehydration. Their fluid chart had not consistently been calculated and we found on occasions they had only drunk 470mls. Their nutritional care plan had not been reviewed following their recent discharge from hospital and previous treatment for dehydration and there was a lack of guidance on how much fluid they should be drinking. The daily handover sheet had also not been updated to reflect the importance of actively promoting fluids.

We recommend that the provider reviews and seeks guidance on their management of hydration.

Care and support was provided to a number of people living with dementia. Guidance produced by the Alzheimer's society advises that a safe, well designed and caring living space is a key part of providing

dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. The environment at Ersham House Nursing Home was not specifically designed for people living with dementia and signage was not readily available. Throughout the inspection, we observed that people could independently navigate the home and find their way about. However, it is seen as good practice for care homes to be dementia friendly. The management team were open to our concerns and after the inspection, sent us an action plan with their intended actions, such as ordering signage.

Staff told us they were well supported and had received the training they needed to be effective in their role. For new staff an induction programme was in place to ensure new starters received the appropriate training, support and guidance to enable them to provide safe and effective care to meet people's needs. New staff were able to shadow a current staff member until they were deemed competent and confident to provide care. There was a programme of training which included essential training for staff. One staff member told us, "I really enjoyed shadowing; it enabled me to work with other staff members and meet the residents." Staff commented that they felt supported and spoke highly of the training provided. Registered nurses received on-going clinical training and supervision which also maintained their continuing professional development.

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered nurses and management team with any queries, concerns or questions.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, district nurses, dentists and chiropodists. People confirmed that if they needed to see their GP this would be organised as required. Staff were proactive in ensuring that the appropriate professionals were contacted to maintain people's health. The GP visited the service on a weekly basis and provided advice and support when necessary. With pride, nursing staff told us how they provided effective nursing care. One nurse told us, "I always ensure I know how people communicate. I use different ways; it might be verbal, or touch, or if someone is very anxious, distraction."

Good

Is the service caring?

Our findings

People we spoke with told us that the staff were caring and treated them with respect. One person told us, "The staff are lovely, ever so kind and always treat me nicely." Another person told us, "The staff are great. We have a laugh and I take the mickey out of them."

People were treated with kindness and compassion, as individuals, and it was clear from our observations that staff knew people very well. Staff spoke with compassion for the people they supported. One staff member told us, "I support one person who is ever so jolly. They love a fry up and cup of tea." Another staff member told us, "The reason I work here, is because of the 'residents'. I love them and really enjoy supporting them." When talking with people, staff maintained eye contact, addressed the person by their preferred name and took the time to listen to the individual.

People's right to privacy was respected. People were assisted discreetly with their personal care needs in a way that respected their dignity. One person told us, "They knock and ask if I want to be washed or showered." Another person told us, "They always knock and ask if it's ok to come into my bedroom." People commented that they were made to feel comfortable at Ersham House Nursing Home and to treat the home as their own. People's rooms were personalised with their belongings and memorabilia. With pride, people showed us their photographs and items of importance. One person spent time showing us all of their family photographs and commented on how they enjoyed having their own television. People commented that staff recognised that their bedroom was their own space and this was respected by staff.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. During the inspection, the hair-dresser had visited the service. Throughout the day, we heard staff comment on people's hair, comments included, 'Your hair looks beautiful' and 'Did you have a perm today? It looks lovely.' Staff recognised the importance of supporting people to dress as they wished. One staff member told us, "We support people to dress how they wish and always encourage their independence with washing and dressing." Another staff member told us, "We always encourage independence. For example, I might say to one person, would you like to wash your face and I'll wash your back."

Guidance produced by the Department of Health advises that for many, 'a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. Too often, however, people with dementia receive undignified treatment and are ending their lives in pain.' People had advanced care plans in place which considered what was important to them, the place they would like to pass away and in their final few days, what they would like to happen. Nursing staff told us how they provided kind and caring end of life care. One member of the nursing team told us, "Communication and pain control. Mouth care and water. Sheets and pillows. Re-positioning. Favourite scents and creams."

Soft toys can be a comfort to many people living with dementia. Staff told us how some people living at Ersham House Nursing Home took great comfort in the companionship soft toys brought them. One staff member told us, "Some people have soft toys, such as teddies, which they sit and hold and that brings them comfort." During the inspection, we observed one lady sitting with their soft toy, staff sat next to them, enquiring about the name of their soft toy and together they came up with a name. Staff understood and recognised the importance these soft toys held for people.

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff.

Guidance produced by Age UK advises on the importance pets bring to older people and the management team had recognised this. The acting manager told us, "Pet pals visit the service regularly. A couple of weeks ago, we had a Shetland pony visit the service. People really enjoyed that and one person in particular came alive when they saw the pony."

Staff had a good understanding of the need to maintain confidentiality. People's information was treated confidentially. Personal care records were stored in locked cabinets. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them. At the end of each shift, staff handed back their daily handover sheet, this minimised the risk of staff taking home the daily handover sheet.

People's equality and diversity needs were respected and staff were aware of what was important to people. A church service visited the home on a regular basis and people confirmed they could attend a local service if they so wished.

Requires Improvement

Is the service responsive?

Our findings

People told us staff were responsive to their needs and worked hard. One person told us, "Staff are very good and look after me. I would say they are very busy though." Another person told us, "I feel staff listen to me and respond." Despite people's positive comments, we found areas of care which were not consistently responsive.

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. During the inspection, we were informed that the service had a recent outbreak of influenza, so a large number of people were preferring to stay in their bedrooms, rather than access the lounge. We also identified a number of people who preferred to remain in their bedroom out of personal choice. Social care plans were in place, but these did not consistently mitigate the risk of social isolation. On the first day of the inspection, we noticed one person who remained in their bedroom all day. They were living with dementia and their care plan referenced, '[person] is very sociable, enjoys the company of other residents will take part in activities. They enjoy watching the T.V. Encourage mental stimulation by reading and watching TV.' They did not have a T.V in their bedroom nor did they have a radio. They spent the whole day in their bedroom with the bedrails up with no stimulation, apart from the interaction from care staff. When care staff did spend time with the person, we found this interaction was not consistently positive. For example, one member of staff was supporting this person to have their breakfast; they did not engage or talk with the person during this interaction.

An activity coordinator was in post who spent one to one time with people in their bedrooms. They told us, "I visit people in their bedrooms for a chat, hand massage, paint their nails or whatever they want to do." We look at the activities log which evidenced what input people had received from the activities coordinator. We found this documentation was not robust and did not consistently evidence what input people received to mitigate the risk of social isolation. For example, documentation often reflected, 'room visit, person sleeping.' Documentation failed to record if they went back, when the person was awake. Other documentation included, 'room visit.' No further information was provided to evidence what that entailed. We reviewed the activity log over a 28 day period and found that people could go up to 11 days without a meaningful visit from the activity coordinator. Staff members also felt this was an area that could be improved. One staff member told us, "I hardly see any one to one activities. I have noticed that some people just sit there." Another staff member told us, "I think for people who prefer to stay in their rooms, the activities could be improved." We queried with people if they felt lonely or bored and people confirmed they were happy remaining in their room, watching the television or reading the paper. One person told us, "Activities are not really for me." Although people raised no significant concerns, we found the risk of social isolation was not consistently addressed or mitigated.

People's care plans did not always detail their life history and important information about them, which meant that staff did not always have clear guidance about what people's care needs were. For example,

details of important events, work history, relatives, favourite sports and activities, places they had lived and important people in their lives. This type of information helps staff to build up relationships and a rapport with people and helps to identify what is important to a person and plan meaningful activities based on their hobbies and interests. We brought these concerns to the attention of the management team who confirmed it would help if the care staff or activity coordinator worked in partnership with people to write their social care plans and address how the risk of social isolation could be mitigated.

Failure to reduce the risk of social isolation is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

For people who enjoyed participating in group activities, a variety of activities were available. One person told us, "We've recently had a valentine's party which was fun and tomorrow we're making pancakes." Another person told us, "We play dominoes, do quizzes and we're going to the cinema in a couple of days, I'm looking forward it." During the inspection, we observed the activity coordinator spending time playing a game of dominoes with a group of ladies. On the second day of the inspection, it was Pancake Day and staff and people gathered in the dining room to enjoy a variety of pancakes.

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. A care plan was then devised based on the pre-admission assessment. These assessments gave a clear account of people's needs in relation to their medicines, communication, nutrition, continence, skin integrity and mobility. Care plans considered the person's assessed need and the actions to meet that assessed needs. For example, care plans considered people's oral hygiene needs and provided personalised actions on how to ensure people's oral hygiene was maintained. One person's care plan noted, '[person] has their own teeth but needs assistance of one carer to encourage them to be able to keep their mouth and teeth clean and healthy.'

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the residents meeting. People and relatives felt they would be listened to and would usually approach the acting manager or nurse in charge as they were both available and approachable. We saw evidence that complaints which had occurred had been recorded and responded to appropriately. One person told us, "I've had one little grumble, but it was managed effectively and I've had no concerns since my grumble."

Inadequate

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the new management team. One person told us, "There have been a lot of changes, but the new manager and deputy manager seem very good." A member of staff told us, "The acting manager is ever so supportive. She also teaches us which is great." Another member of staff told us, "The manager is ever so approachable."

Staff spoke with pride for working for Ersham House Nursing Home. One staff member told us, "I think it is brilliant here. It is a brilliant team and the management are so supportive." Another staff member told us, "I would describe our key strength as caring. We do care and try our best." Staff spoke highly of the leadership style of the management team and acknowledged that the service had been through a bumpy patch but staff felt morale had considerably improved.

Whilst all feedback of the management was positive and we could see that significant changes were taking place, these changes were not yet embedded into practice.

A registered manager was not in post. The acting manager told us, "The previous manager left at the end of October 2016 and they left without notice. The impact of the manager leaving, subsequently left staff in a state of turmoil and uncertainty. Myself and the deputy manager have only been in post four months and we have spent time supporting staff to feel settled and ensuring that they did not find alternative employment. We have also been focusing on recruitment, making sure we find the right people to enhance the team. Time has also been spent selecting and supporting new senior care assistants into their new role which, as they develop into that role, will make a significant impact with regard to the improvements identified as being required. We are working hard to make the desired improvements." The acting manager was planning on becoming the registered manager.

At our last inspection in May 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the registered provider had failed to maintain accurate and complete records. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2016. At this inspection, we found steps had been taken and improvements had been made. However, we found continued shortfalls in relation to accurate and complete records being maintained.

Each person had a range of documentation in place, these included, food and fluid charts, repositioning charts and topical medicines records. We found a range of discrepancies with people's topical medicines records. For example, one person was prescribed a soap supplement which was to be used daily instead of soap. Documentation reflected it had only been used on six occasions between the 1 December 2016 and 19 January 2017. Documentation also reflected it had not been used since the 19 December 2017. Another person was prescribed a cream that required application twice a day. Documentation recorded that it had only been applied on the 1 December 2016, 18 January 2017, 16 February and 17 February 2017. Bowel movement charts also contained omissions and unexplained gaps. For example, one person's bowel movement chart reflected they had not had a bowel movement in 12 days. Another person's bowel

movement chart reflected they had not had a bowel movement between the 31 January and 10 February 2017. A member of the management team told us, "We have implemented 'resident of the day' which is where once a month we review a person's care plan in depth. However, as part of this, we also need to review their bedroom notes to check for omissions. This will be an area we will focus on from now on."

Care plans were subject to a formal audit (resident of the day). We found that the care plan audit process was robust and identified shortfalls within the care planning process and how the care plan could be improved. However, where care plans had not been audited, we found numerous discrepancies in record keeping. For example, one person's fall risk assessment was completed on the 20 October 2015 and reviewed in December 2016 where recording stated, 'no changes to falls risk assessment.' However, this person had input from the physiotherapy team in September 2016 who provided a range of activities to prevent falls. This intervention and instruction had not been updated within their care plan or falls risk assessment. Another person's continence care plan identified they had a catheter in situ. However, subsequent monthly reviews, identified the catheter had been removed, yet this hadn't been updated in the main body of the continence care plan.

A daily handover sheet was in place which provided an overview of individual's needs. As the service had a high level of agency use, this handover sheet acted as a useful tool as agency staff confirmed they had not yet read people's care plans. The management team told us this handover sheet would be updated daily to reflect people's changing needs. However, we found it had not been updated daily. For example, one person was admitted to hospital on the 23 February 2017. We found the handover sheet recorded 'gone to hospital this morning' until the 27 February 2017 when it was updated to reflect the date of their hospital admission. Another discrepancy included the handover sheet recording for 'reassurance required that they will be going home.' However, their daily notes from the 15 February 2017 recorded that a decision had been made for this person to remain at the service on a long term basis. Failure to have an up to date and accurate handover sheet could pose the risk of unsafe practice.

On the second day of the inspection, we arrived at the service at 08.00am. We observed that one person was in bed with their breakfast still in front of them, uneaten. Their nutritional care plan identified they required one to one support with eating and drinking. However, their food and fluid chart for that morning recorded they had eaten all of their breakfast. We brought these concerns to the attention of the management team who took action immediately. We then checked the person's food and fluid chart later on and found it still contained omissions. For example, staff had then failed to subsequently record how much the person was supported to eat.

Failure to maintain accurate, complete and contemporaneous records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved and details of the incident/accident. However, follow up information was not consistently recorded. For example, the steps taken to reduce any further incidents and accidents. We queried with the acting manager where incidents and accidents were subject to a formal audit to monitor for any emerging trends, themes or patterns. They told us, "The previous manager would have completed an audit, but one hasn't been completed since they left last year." We identified one person who had experienced three falls in the space of three days. The absence of an incident and accident audit meant the management team had not been looking for patterns as to whether people were falling at the same time of day and the underlying root cause for a number of falls in a short period.

A quality assurance framework was in place which consisted of a range of audits and action plans. For

example, where concerns were raised from a staff member, the management team used these concerns as an opportunity to develop and improve practice. One member of staff raised concerns over poor handover and poor medicine administration. An action plan was developed and action included for the handover sheet to be updated immediately and for a medicine error investigation to take place. The acting manager had an improvement plan in place with on-going actions which included for all care plans to be continually audited under 'resident of the day.' Following a visit from the local commissioners, the management team implemented an action plan following their feedback. However, despite a quality assurance framework in place, we found this framework was not consistently robust. For example, the provider's internal medication audit failed to identify that nursing staff were not consistently recording the date and quantity of homely remedies administered.

The management team were dedicated to the on-going improvements of Ersham House Nursing Home. A member of the management team told us, "When I first started here, it wasn't that great, but we have come a long way, but there are still on-going improvements." Although a quality assurance framework was in place and had identified concerns with documentation, the provider's internal quality assurance framework had not consistently identified the shortfalls noticed during the inspection. For example, they had not identified concerns with the risk of social isolation, task centred practice, diabetic risk assessments and principles of the MCA 2005 not always being adhered too. Where quality assurance audits were in place, these had not consistently identified shortfalls and how improvements could be made. For example, the provider's internal medication audit failed to identify that nursing staff were not consistently recording the date and quantity of homely remedies administered. During the inspection, the management team were open and responsive to our concerns and after the inspection, sent us an interim action plan based on our initial verbal feedback.

Systems were in place to involve people, relatives and staff in the running of the service. Staff and 'resident' meetings here held regularly and satisfaction surveys were used as a tool to gain feedback from people. The last satisfaction survey from 2016 found that 38% of staff disagreed that communication worked well within the service. Twenty-five percent of staff also felt that they were not listened too and 45% of people neither agreed nor disagreed that the activities were varied and met their needs. An action plan was produced following the results of this survey and how improvements would be made. However, the action plan had not been reviewed to see if all actions had been met or if any actions were on-going.

The governance of the premises and maintenance was not well-led. In 2014, a fire risk assessment had been completed which identified a number of actions. In 2016, the service was inspected by the East Sussex fire brigade. That inspection identified a number of shortfalls such as, 'matters identified during the fire safety audit carried out on the 29 February 2016 indicate that the fire risk assessment has not been adequately reviewed to address the significant findings following the fire risk assessment dated 7 August 2014.' The fire inspection also recorded, 'all items to be addressed including the significant findings identified by your fire risk assessment dated 7 August 2014 with suitable action plans put in place to address these by 30 March 2016.' The provider told us they had addressed the concerns identified during the fire inspection. However, they had not compiled or completed an action plan to demonstrate when actions had been completed or the progress of unmet actions. We also found that the fire risk assessment had been not reviewed since 2014. The provider's gas certificate had also expired on the 13 February 2015. Their latest oil installation was also completed on the 6 March 2015 when the engineer failed the check on two issues. These issues were in relation to the oil storage and safety controls with the fire walls. Comments from the engineer identified, 'a fire hazard has been identified with the proviso that it is strongly recommended these faults be remedied urgently.' We asked for evidence that this work had been completed and the acting manager told us that the follow up action has been missed but it has been organised for the 28 March 2017. This meant for two years, urgent remedial work had not been acted upon and the provider's internal quality assurance framework had

failed to identify this shortfall.

The ethos of the service was not consistently person-centred. For example, we found that the service was often task oriented and the ethos and values of person-centred care was not fully embedded into practice. Guidance produced by Skills for Care advises that for a service to have a person centred culture, staff need to understand that 'each person has their own identity, needs, wishes, choices, beliefs and values. One size fits all does not work when it comes to providing care and support.' During the inspection, we heard staff refer to people in an inappropriate way. For example, during the inspection, the call bell system rang a lot. When responding to call bells, staff would call out people's bedrooms numbers rather than their individual names. Often, we heard staff shout, "Room 22 is calling. Now its 15 and now 21." We also heard staff refer to people by their room number instead of their preferred name. For example, we heard one interaction, "They in room 22, they can't stand can they?" When supporting people to eat and drink, we also heard staff make reference to 'feeds' instead of people. For example, one member of staff commented, "Feeds are nearly done." We brought these concerns to the attention of the management team, who acknowledged they were working hard with the care team to make positive changes and embed a culture of person centred care.

The failure to have a robust and effective quality and safety assurance systems is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes any allegation of abuse, any serious injury to a person and Deprivation of Liberty applications and their outcomes. The acting manager was aware of their responsibility and had notified us about deaths, allegations of abuse and serious injuries to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide care and treatment that met service user's needs, was appropriate and reflected their preferences. Regulation 9 (1) (a) (b) (c).

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 The provider had failed to provide safe care and treatment. The provider had failed to assess the risks to the health and safety of service user's and had not done everything that was reasonably practical to mitigate such risks. Regulation 12 (1) (2) (a) (b).

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 11 HSCA RA Regulations 2014 Need for consent The care and treatment of service users was not provided with the consent of the relevant person. The registered provider had failed to act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3).

The enforcement action we took:

We served a Warning Notice.

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 The registered provider had failed to assess, monitor and the improve the quality and safety of the service provided. They had also failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous records had not been maintained. Regulation 17 (1) (2) (a) (b) (c).

The enforcement action we took:

We served a Warning Notice.