Loven Larchwood Limited

Larchwood Nursing and Residential Home

Inspection report

133 Yarmouth Road
Thorpe St Andrew
Norwich
Norfolk
NR7 0RF

Tel: 01603437358
Website: www.bondcare.co.uk/care-homes/larchwood-nursing-home/

Date of inspection visit:
12 March 2018

Date of publication:
01 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 12 March 2018. Larchwood Nursing and Residential Home provides nursing and accommodation for up to 48 people. At the time of our inspection, 32 people were living in the home.

Larchwood Nursing and Residential Home is a 'nursing and residential home'. People receive accommodation and personal care as a single package, and some people receive nursing care as a separate package. CQC regulates both the premises and the care provided, and these were looked at during this inspection.

Larchwood Nursing and Residential Home accommodates people in individual rooms, each with an en suite toilet and basin facility. Each floor has some communal bathrooms and toilets in addition.

We last inspected this service on 19 September 2017. At that inspection, we found eight breaches of the Health and Social Care Act 2008, and one breach of the Care Quality Commission (CQC) Registration Regulations 2009. The service was rated 'Inadequate' in four areas, which were safe, effective, caring and well-led. The service was rated 'Requires Improvement' in responsive. The overall rating for this service was 'Inadequate' and the service was therefore in 'special measures'. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are to be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Following that inspection we took action against the provider and met with them to confirm what action they would take to improve the service. We served a Notice of Decision to impose positive conditions on their registration, which they have complied with. During this inspection, we checked to see if the provider had made sufficient improvements. We found there were five continued breaches, however improvements had been made. The provider was no longer in breach of the remaining four regulations.

There was not a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, there was a manager in post who had been appointed in January 2018, who was applying to register with the CQC. They will be referred to as the 'manager' throughout the report. During the inspection, a representative from the provider's organisation was also at the location. For the purposes of this report, they will be referred to as the 'provider'.

At this March 2018 inspection we found that the provider had not made all the improvements required since our last inspection, in a timely manner. However, auditing and quality assurance systems had improved and were in place. We found at this inspection that whilst they identified some concerns, they did not pick up all of the areas where the provider remained in breach. As the manager had only been in post a short space of

time, we remain concerned about the sustainability of the improvements to the service.

Further improvements were needed around infection control processes. Despite improvements made, there were not always good infection control practices within the home. The kitchen was dirty and there were poor hygiene standards with regards to storing laundry.

The safety of people living in the home had improved, however further improvements were needed. These were especially in relation to pressure care, and risk management. There were improvements in the management of risk, however some pressure care was not always carried out and recorded.

There were some improvements needed to fire safety within the home, such as ensuring that evacuation plans were up to date and equipment was tested. There were some unsecured prescribed medicines around the home. On the whole, medicines administration had improved but improvement in the oversight of medicines was still needed.

There had been improvements in the provision of activities, and further improvements were needed to ensure these were tailored to people's preferred hobbies and interests. People did not always receive care that was individualised and met their preferred needs. The care plans did not always reflect people's needs accurately. The care plans were undergoing improvement by the staff.

There were not enough staff to fully mitigate risks to people and to supervise communal areas of the home, however improvements had been made to increase staffing since the last inspection. Staff received training and supervisions relevant to their roles and they were aware of their responsibilities.

Falls risk assessments were in place, and some were more detailed than others. A new care planning format outlined specific risks to people and guided staff on how to mitigate these. The manager had prioritised those at highest risk when they carried out the redoing of care plans. The existing care plans contained some information about how to mitigate risks to people.

Significant improvements in the management of people's diets had taken place, where people had been identified as being at risk of weight loss. Further improvement was still needed with regards to people's records to demonstrate they were regularly offered snacks and they received their supplements properly. People had enough to drink. People were often given choices of food, however there remained times when staff did not offer this.

There were caring interactions within the home, but some staff did not always have a caring approach to people. There were overall improvements to people's dignity being upheld within the home since our last inspection. The manager had a good understanding of people's mental capacity and staff asked for consent before delivering care.

Staff were well supported by the manager, who was visible throughout the home. They had made contact with people's families to involve them in their relative's care, and address the concerns following the last inspection. The manager had arranged meetings for people living in the home and their families, and had an open door policy so people and staff could raise concerns easily.

The manager had taken disciplinary action where appropriate, and was working with other organisations such as the CQC to improve the home.

The overall rating for this service is 'Requires Improvement'. The rating for 'well-led' in this service is

'Inadequate' and the service therefore remains in 'special measures'. For the remaining four key questions, the ratings are 'Requires Improvement.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

The service was not always safe.

Risks to the health, safety and wellbeing of people who used the service had not always been fully identified, assessed and planned for.

There were enough staff to keep people safe.

Recruitment processes were in place to ensure that staff suitable to work in care were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity was understood and staff asked for consent before delivering care to people, although records did not always reflect full and accurate decision-specific assessments.

People were supported to eat and drink enough and access healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive care that was compassionate, from caring staff.

People were supported to maintain their dignity and privacy, although staff did not always follow best practice to ensure they encouraged people's independence.

The service was beginning to involve people more in their care and their relative's care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met in a person-centred way.

Staff were not always available to people within communal areas.

People's health, emotional and social needs were not always fully planned for. Improvements were needed in respect of plans to meet people's preferences and health conditions, and these were under way.

Activities were on offer to people through the week, and further improvements were required to the provision and quality of these.

The service learned from complaints and worked to improve the home.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not make significant improvements in a timely manner following the last inspection.

Systems in place for auditing and monitoring the service were not always effective as they did not always identify concerns or lead to actions. A home improvement action plan was in place and the service was still making improvements.

There was improved leadership in the home and the manager was aware of their responsibilities.

Larchwood Nursing and Residential 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 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.

This inspection took place on 12 March 2018 and was unannounced. The inspection team consisted of two inspectors, a medicines inspector, a specialist nurse advisor and an expert 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.
As part of the inspection, we reviewed the information available to us about the home, such as the notifications and the action plans that they had sent us. A notification is information about important events which the provider is required to send us by law. We also obtained feedback from interested parties, such as the clinical commissioning group.

During the inspection, we spoke with nine people living in the home and two relatives. In addition, we spoke with one care worker, the head of care, a nurse, the manager and a representative from the provider. A medicines inspector looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines. A specialist advisor looked at records related to people's nursing care, including any specific health conditions and pressure care. We observed lunch time, activities, and how care was delivered throughout the day of our inspection. We looked at six care records and checked through the daily records of people's care. We also looked at a range of management documentation relating to how the home is run, such as audits and staff training.

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 19 September 2017, we found the service was not safe, and was rated 'Inadequate' in this area. During this inspection, we found that improvements have been made, significantly in some areas. However, there were further improvements needed to ensure that the service was always safe.

At our inspection on 19 September 2017, we had concerns about the assessment and management of risks around infection control. We also had concerns around medicines management and the management of risks to people's health and safety. The service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made, however the provider remained in breach.

At this inspection, we remained concerned about the level of cleanliness within the home. We found that the kitchen was very dirty, with food debris, grease and dirt ingrained in the equipment, the walls and the floor, and not all food that had been opened had been dated. This posed a risk that food coming out of the kitchen could be contaminated, and therefore could impact people's health. When we brought this to the manager's attention, they immediately ensured that a deep clean was carried out over the next two days in the kitchen.

We also saw that dirty laundry was being stored alongside clean laundry in a communal bathroom. This posed a risk that contamination could spread from dirty laundry to clean laundry. Clean laundry was also being stored uncovered next to the toilet, and could as a result become contaminated. Furthermore, people could access the dirty laundry. We brought this to the provider's attention who told us they would resolve this issue immediately. There were also areas in the bathrooms of visible lime scale on the taps.

We also saw that not all equipment people used was kept clean. For example, we saw that a hoist was dirty with old crumbs and dirt on it. This was being used throughout areas of the home to support people to move. The practices we observed presented a risk that infections could be transferred and any outbreak would not be properly managed to ensure people's safety. We saw that the provider had taken some action following a recent visit by the Clinical Commissioning Group (CCG) who had identified these concerns. Further action was still needed to comply with regulation and sustain compliance.

We observed a communal lounge area for a period of time in the morning and noted a strong malodour. During the morning we observed domestic staff spraying the chairs with a chemical and wiping with a cloth. They used the same cloth for all of the chairs and then proceeded to use the same cloth to wipe the small tables and the windowsill. This was poor infection control practice.

At our last inspection on 19 September 2017, we had serious concerns about pressure care for people. At this inspection, we found that significant improvements had been made in relation to people's pressure care. However, improvements were still needed to ensure this was consistent. We saw that one person did not have their required pressure cushion in place on the chair they were sitting on. We found that there were

gaps in charts where staff recorded supporting people to reposition due to their risk of developing a pressure ulcer. For two people, we saw several gaps in their records over the last week of between four and six hours, when their care plan suggested repositioning every two hours. For another person, we saw that their care plan recommended the use of a pressure relieving boot. This was not being used on the day we inspected.

For another person we found that although there was a comprehensive care plan for their skin integrity, which suggested the person was at high risk of developing a pressure ulcer, there was no evidence in their daily records that their skin was regularly being checked. We saw a body map for the person dated 10 December 2017 which recorded the person had redness. The following body map was dated 7 March 2018 and recorded a grade 2 pressure ulcer. There were no records to show the deterioration of the skin. We could not be assured that the person's pressure ulcer was picked up in a timely way by staff, as there was not sufficient information recorded about their pressure care.

There was not always detailed guidance for staff about how to support people with specific conditions. For example, one person's care plan stated they required blood sugars to be checked 'occasionally', to ensure they remain 'safe', but with no further information about when this meant. The manager told us the new care plans would have more specific information and detail about people's conditions.

Staff did not always use equipment in a safe way. During our inspection, we observed on two separate occasions people being pushed in wheelchairs with no footplates. This presents a risk that peoples' feet will get stuck, potentially leading to pain and fractures.

We saw that people had a Personal Evacuation Plan (PEEP) in their care plans. However, the PEEPs were not always accurate, for example, one person's PEEP stated that they were able to understand and follow instructions, but their mental capacity assessment stated that the person was not. This presented a risk that in the event of a fire, staff may not have the accurate guidance in place to bring the person to safety.

We saw that weekly fire checks had not all been completed since 27 December 2017, including the alarm checks and fire doors. This presented a risk that fire equipment may not be fully operational in the case of an emergency.

We had some concerns around hot pipes and radiators throughout the home, which posed a risk of scalding to people, especially those at risk of falls. The provider took immediate action to order the materials to cover these and complete the appropriate risk assessments. They informed us shortly after the inspection visit that this work had been done.

We noted areas of the home where external medicines and hazardous substances were not secured and where people could access them placing themselves at risk of accidental harm or ingestion.

All of the above concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 19 September 2017, we found there were not enough competent staff to deliver care to people. The service used a dependency tool to assess staffing levels required, which was inappropriate for the environment. This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had to wait for a long time for support, and were left unattended and crying out for long periods of time and left without call bells. We also had concerns about the competence of staff deployed in the home who did not deliver safe care. We found during this

inspection, that staffing levels had improved and there were more staff, however there were still not enough competent staff to fully mitigate risks to people and the service remained in breach of this regulation.

There were more staff available to people and we saw safe care being delivered. However, we had mixed feedback about staffing levels from people. One person said, "The [staff] are nice, I wish there were more at times but they do their best when they come." Another person said, "I feel safe on the whole, but I think sometimes they could do with more staff on duty." Another person told us that they had to wait a long time at night if they called their bell. A relative confirmed to us that they felt the home was safer because the staffing had improved. We observed periods of time when staff were not available within the communal lounge downstairs. On one occasion, there were two relatives in there who supported people living in the home by checking that they were comfortable. We observed one person pour their cup of tea onto the floor and a relative of another person intervened as there were no staff in the lounge at that time. We concluded that further improvements were needed to ensure that staff were available to deliver care to people within communal areas of the home, and at certain busier times of the day.

The above concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We had some concerns around the care planning relating to people's medicines. One person's care plan stated they had no capacity to make decisions, however another part of their care plan stated the person was able to ask for pain relief. This meant it was difficult to be sure of how to administer a PRN (as required) pain relief. The manager told us they were aware of this and these issues were being addressed in the new care plans as they were rolled out.

The manager was aware and able to tell us accurately who had pressure ulcers. They ensured they gained regular feedback from staff with regards to pressure areas. We saw from records that other existing pressure areas in the home were healing.

At the last inspection in September 2017, we found that medicines were poorly managed and not recorded safely, and they were not given as prescribed. One person told us, "Nurses give me my medicines, they know when to bring it." A relative said, "Sometimes [staff] have been late with [relative's] medicines." A member of the CQC medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines.

Staff authorised to handle and give people their medicines had recently received training and had their competence assessed to ensure they managed people's medicines safely. We observed part of the morning medicine round and saw that staff gave people their oral medicines safely and in a caring manner.

Audits were in place to enable staff to monitor medicine administration and their records. However, we found that there were some discrepancies and gaps in records so they did not always confirm people living at the service received their medicines as prescribed. This included medicines prescribed for external use such as creams and ointments. However, there had been improvements in the service obtaining them for people, since our last inspection in September 2017.

Some supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification to help staff give people their medicines safely. There were additional records in place for high-risk medicines to ensure safety. For people prescribed skin patches, there were additional records showing they were applied safely to reduce skin effects and confirming they were later removed before the next patch was applied.

However, information about people's known allergies and medicine sensitivities in notes and on medicine charts was sometimes inconsistent which could have led to error particularly when new medicines were prescribed. Some people were prescribed medicines on a PRN basis, such as medicines prescribed to assist with psychological agitation. There was not always sufficient detail to show staff how and when to give them to people to ensure they were given consistently and appropriately. For one person, their care plan referred to a when-required pain-relief medicine being used when they were in pain. However, we noted this was not currently in use and had been stopped by the prescriber. This could have led to confusion and error. For medicines prescribed for external use, there was sometimes insufficient written information or body charts in use to show staff where on the person's body and how frequently they should be applied.

For a person with limited mental capacity to make decisions about their treatment and who may refuse their medicines, there were records of mental capacity assessments. There were also documented best interest decisions to give them their medicines crushed and hidden in food or drink (covertly). The service had consulted with and obtained written guidance from the pharmacist about how to give the person their medicines in this way. However, we noted members of staff were not following this advice for one of the medicines when they gave them to the person.

Staff dated medicines such as eye drops and creams when they were opened. This should contribute to ensuring staff disposed of them promptly when necessary. However, we noted an oral medicine that was still in use following its expiry date. A member of staff later found that a replacement medicine had been obtained but this had not yet been put in place for use.

At our last inspection on 19 September 2017, we found that the registered manager had not reported incidents to the safeguarding authorities as expected. This resulted in a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that since they had been in post, the manager had reported any notifiable events to the safeguarding authorities and sought advice. One person told us, "I feel safe and not lonely." One staff member told us they felt the home was safer because the staff had received more training, and felt comfortable to raise concerns. The staff we spoke with understood how to report concerns, and what types of incidents they would report. The manager had communicated consistently when needed with safeguarding authorities, and we saw records of referrals made.

With the exception of staff using wheelchairs without footplates, risks associated with people's mobility and falls were being assessed, although not always with full details on how to mitigate risks. The manager had prioritised people at highest risk of harm to redo their care plans first, before completing this for everyone in the home. This was an improved care plan format which outlined risks to individual people. We found that the risk assessments had been updated to include existing risks to people, for example about falls and pressure care. We reviewed the falls risk assessment for one person in the new care plan. We saw that this was detailed with person-centred information, and included details about the environment and guidance for staff. Although some care plans were not yet updated, staff understood individual risks to people. They took action to minimise them and promote people's safety. Staff also continued to update the existing care plan with new information relevant to people's risks.

We looked at records of accidents and incidents. We saw that the manager had taken action where there had been unsafe manual handling practices in the home. We observed that staff used a hoist safely to move people between their chair and wheelchairs.

The registered manager had reviewed reports of accidents such as falls, and had used these as an opportunity to improve the service. The manager had taken action where possible, such as putting further

equipment in place to minimise a risk of falling.

There were risk assessments in place for people's environment which mitigated risks, including checks of electrical equipment and lifting equipment. There were water checks and a risk assessment for legionella. We made the provider aware that this was overdue for review, and they told us they would organise this to be completed again.

Staff were employed with safety checks in place, such as the Disclosure and Barring Service (DBS) checks and references. This meant the provider recruited staff that they deemed suitable to work in the home.

Requires Improvement

Is the service effective?

Our findings

During our last inspection on 19 September 2017, we found the service was not effective and was rated 'Inadequate' in this area. During this inspection, we found that improvements had been made, significantly in some areas. However, there were further improvements needed to ensure that the service the service was always effective.

At the last inspection on 19 September 2017, people's mental capacity to make specific decisions was not always fully assessed. The service could not show that decisions made were always in people's best interests, constituting a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was limited recording of people's mental capacity and staff had a poor understanding of the Mental Capacity Act 2005 (MCA). We concluded that there was no longer a breach in regulation in this area. However, further improvements were still needed to complete the records and ensure the care plans were completed and adhered to.

The 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).

During this inspection, we found that significant improvements had been made in this area. Although the new manager had not completed all of the recording around individuals' mental capacity and best interest decisions in their care plans, we reviewed a care plan which they had completed fully. This was the plan that was being rolled out across the home once everyone had been reviewed. The person's mental capacity had been properly assessed, and the assessment outlined specific decisions, and how to support the person to make these. It also outlined who would be involved in any best interests' decisions. However, the care plans which had not yet been redone did not all contain enough information about people's capacity for specific decisions.

The people we spoke with confirmed that staff asked for consent before delivering care. The manager had good knowledge of the MCA and the staff had improved knowledge.

At our last inspection on 19 September 2017, we were concerned that staff did not have adequate training or checks on their competence and skills. These concerns had contributed to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that significant improvements had been made in this area and the provider was no longer in breach in this area. One person told us, "The staff seem to be well trained." Another told us they felt safe when staff supported them to move using equipment. Staff told us about training they had received, and this included additional

training for nursing staff. We found during this inspection, that staff had received supervisions and competency checking, and actions had been taken when staff competency was not found to be adequate.

We saw records of supervisions where senior staff had addressed areas of concern with staff such as accurate record keeping and safe manual handling. Other areas discussed with staff included consent, dignity and communication. Staff had also received further training in their roles. This included dementia awareness training, diet and nutrition, dignity, fire safety and safeguarding.

During our previous inspection on 19 September 2017, we had significant concerns about support for people who were at risk of losing weight. This constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that improvements had been made, and the provider was no longer in breach of this regulation. However, further improvements and care planning for diet and nutrition were still needed.

One relative we spoke with told us that the manager had addressed some concerns they had around their relative losing weight and not getting enough to eat. We saw that improvements had been made to the provision of food and drinks for people. People confirmed that they received enough to eat and drink. One person reflected improvements that had been made during the last year, "I ask for water and have enough, the food is good. In the beginning I asked for more food and I was hungry." They said that staff knew their preferences now and got them extra sandwiches to have in the evening. We saw that people had a drink within reach throughout the day of our inspection visit.

People said they had enough to eat and drink, but this was not always properly recorded and monitored for people at risk of not eating or drinking enough. There were food and fluid charts in place for staff to keep a record of what people had to eat and drink. These were not always completed fully, and there were gaps where no offering of snacks had been recorded, despite them being recommended in the care plan. There was limited oversight of these as the recording was inconsistent and the amounts were not totalled and analysed. Improvements were required to this so that the records can be used effectively to oversee and improve people's care. There was also some inconsistency within people's records about their diets, for example, one person's care plan said in one part that they required a diabetic diet, and in another, a normal diet. This could cause some confusion and a risk that people may receive incorrect meals.

There were improvements since our last inspection in September 2017 in the way that people at risk of weight loss were supported. Records we looked at showed people had gained weight consistently and this was being managed effectively. We also saw that the appropriate referrals were being made when needed, for example to a speech and language therapist (SALT) or dietician.

We received mixed feedback about whether people were always offered a choice of food. Two people said that sometimes care staff asked them what they would like. One person said, "[Staff] just put [the meal] down, although one or two times they have been in and asked what I wanted to eat the next day." During our inspection visit, we saw that the picture menu upstairs in the dining area was three days old. This did not contribute to people being able to make meaningful choices about what they wanted to eat.

The environment was not always suitable to meet individual's needs. For example, one person told us they could not get access to the en-suite toilet in their room because the equipment they used was too big for it. They required a stand aid to support them to transfer, and therefore the person had to use a commode instead of a toilet. There was an improvement plan in place to refurbish areas of the home, which included updating bathrooms.

The manager had good knowledge of how to assess people and the new care planning format allowed for a lot of detail to be added in respect of people's needs and how staff should support them.

The manager and the provider had sought advice as needed from the safeguarding team and the local authority to improve the service, and engaged in meetings as required. They communicated with CQC and worked with other agencies such as the Clinical Commissioning Group (CCG) and the local authority to work towards improving the service.

People confirmed that they had access to healthcare such as a dentist, GP and chiropodist when needed. We saw that referrals were made appropriately to other healthcare professionals when needed.

Requires Improvement

Is the service caring?

Our findings

During our last inspection on 19 September 2017, we found the service was not caring and was rated 'Inadequate' in this area. During this inspection, we found that improvements had been made, significantly in some areas. However improvements were needed so that people consistently experienced a good, caring service.

At our last inspection, we had concerns that people's dignity and privacy was not upheld. Furthermore, people and their families were not involved in their care planning. These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that significant improvements had been made in this area and the provider was no longer in breach of this regulation.

During our inspection visit, we saw that people's dignity and privacy was upheld, and that staff were able to deliver care when people needed it, for example, to use the toilet. People were not left in undignified situations, and staff carried out personal care in private.

The service was improving the involvement of people and their families in making decisions and choices about their care, where appropriate. One relative told us the new manager was involving them in their family member's care, and had arranged to meet with them about it. We concluded that further improvements were still needed because the manager had not yet had time to meet with all of the families concerned and create new care plans for everyone.

Further care was needed around people's belongings. A person living in the home told us that their shoes had gone missing. One relative showed us in their family members' room, that some clothing had been returned to their drawers that was not theirs, and some had been discoloured in the wash.

We saw some practice during the lunch time in the home which did not demonstrate a caring manner. A staff member supported someone to eat without getting down to eye level, and without the appropriate interaction. The practice did not show a caring interaction or uphold the person's dignity. We told the manager about this and they said they would take further action with the staff member concerned. They later confirmed they had taken appropriate disciplinary action. We also observed that some people eating at lunch time could have benefitted from plate guards to support them to eat independently. The manager told us they were working to improve the culture of the home to make it more caring.

At times, there were missed opportunities for interaction which staff did not take. We observed task-led practice with regards to caring. We observed one member of staff say to another when bringing people in the communal lounge, "Let's just get everyone and we can transfer them all." This did not demonstrate a positive and caring attitude towards people as individuals. This resulted in four people being left in their wheelchairs and two of these were for one hour, with one person stating that they were uncomfortable. This also demonstrated that staff did not always take opportunities to increase and maintain people's independence, at times having a task-led approach to care. People who were independently mobile were

able to move freely about the home. The promotion of people's independence required further improvements

One person told us they felt the manager had been proactive in improving caring within the home, and that staff in the home are more caring now. We received mixed feedback about whether the service was caring. One person said, "On the whole, [staff] are very nice." However, one person said, "Some [staff] are very harsh." A relative explained that some staff were caring in explaining what they were doing when supporting their family member to move using equipment, but not others. We saw that recent competency assessments had identified some associated issues with care staff. The manager had taken further action which included supervision and disciplinary procedures.

All of the people we spoke with told us that staff were polite to them. However, one relative said, "Staff just sit there and don't talk to people." They added that they felt the culture of the home was improving under the new manager, but further improvements were needed. We saw that at times staff took opportunities to interact with people, chatting with them in communal areas of the home and responding to requests for assistance.

One person showed us some flowers that care staff had picked for them. They told us this had cheered them up. All of the people we spoke with told us they felt comfortable to raise any concerns with staff. Some people told us that staff supported them to increase their mobility and be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 19 September 2017, we found the service was not responsive and was rated 'Inadequate' in this area. During this inspection, we found that improvements had been made, significantly in some areas; however improvements were needed to ensure people experienced a consistently good, responsive service.

At our previous inspection in September 2017, we found the service did not deliver person-centred, individualised care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we concluded that although improvements had been made, the provider was still in breach of this Regulation.

There were improvements in the feedback we received from people about the responsiveness of the service. One person told us, "We are well looked after, whatever I ask for I get, they do everything they should do." However, they added, "I fit in with [staff's] routine." They added that they had support to go to bed when they wished. Another person said this had improved for them, saying, "At first I had to go to bed early in the evening, but now [staff] know I like to go at 10.30 and I do."

One person told us that staff did not always get to them in the morning at a time they liked to get up and they had to wait. During the inspection, two people and a relative informed us that there was only one stand-aid available. This is a piece of equipment staff use to help people to transfer. We saw during our inspection visit, that staff answered one person's call bell, and informed them they would have to wait for assistance to go to the toilet because someone else was using the equipment. This meant that staff were unable to be responsive to the person's immediate needs.

When we inspected in September 2017, we were concerned that people had not been supported to have regular baths. We remain concerned as we received mixed feedback about this, however improvements had been made. One person confirmed they had a shower with support from staff when they chose. A relative confirmed that their family member was now receiving regular support to have baths, which they were not getting previously. We checked some people's daily records and were concerned that these did not always reflect that people were offered baths regularly. For example, for one person, they had not received assistance to have a bath or shower in at least twelve days, and had received a bed bath. The person's care plan stated that they enjoyed baths, and their relative confirmed this.

We saw a significant improvement in the accuracy of daily records filled in by staff. However, daily records did not always reflect people receiving care as per their care plan. Staff had not always recorded if a person was offered care and refused, and we saw that some people had not had always received care according to their care plan. For example, one person's care plan stated they enjoyed a bath, and should have this once or twice weekly. The daily records showed that they had not been supported to have a bath or hair wash since the beginning of the record which was 1 March 2018. Staff had supported them with bed baths most days. According to the daily records, people were not always supported to clean their teeth as per their care plans.

We received mixed feedback about activities provision in the home. "Once a day I ask a [staff member] to walk with me around the corridors." However, another person told us, "[Staff] got me walking the other day down the corridor but they don't have time to do it very often." We saw that the provision of activities within the home had improved since our last inspection, but further improvements were needed to the care planning around these. During the day of our inspection, there were activities taking place, such as musical bingo, and different activities and entertainers were on offer throughout the week. The new care plan we looked at outlined the person's preferences, likes and dislikes with regards to engagement in activity, and the manager told us they were collecting this information for everybody in the home. This would contribute to improving person-centred activities.

Two relatives told us that some staff had said they did not have time for activities because they had too much paperwork to do. We fed this back to the manager to address. One relative told us, "I don't think there are enough activities." They said that this had improved recently. We found that the records relating to people's activities did not have valuable information. We looked at records which said that interaction or stimulation was provided. There was no information about what this meant.

The above concerns constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were being reviewed regularly and were still in the process of being redone. Existing care plans did not always have full information about supporting people's mental health and emotional wellbeing. However, the new care plan format and the information gathered in those that were complete was individualised, with accurate guidance for staff. One staff member told us that any changes in people's care were effectively communicated through staff handover discussions between shifts.

The people we spoke with confirmed that they chose whether they had a female or male member of staff to support them with personal care. People were supported to spend time where they wanted and could remain in their rooms if they wished. People were supported to see the hair dresser.

There was a complaints procedure in place. The people we spoke with told us that they found the new manager approachable to bring concerns to. One relative confirmed that they had brought their concerns to the provider and the manager, and they felt that action was being taken. We saw that formal complaints had been investigated and recorded.

The new care plans contained detailed information about how people wished to be supported towards the end of their lives. This contained information about people who were important to the person and where they wanted to be. This had not yet been completed for everyone in the home and was part of the manager's improvement plan in redoing the care plans.

Inadequate

Is the service well-led?

Our findings

During our last inspection on 19 September 2017, we found the service was not well-led and was rated 'Inadequate' in this area. During this inspection, we found that improvements had been made, significantly in some areas; however there were further improvements needed to ensure good leadership and sustainability.

At our last inspection on 19 September 2017, we found the provider was in breach of regulation 18 of CQC Registration Regulations 2009, because they had not informed us of notifiable incidents. At this inspection, we found the manager was transparent and communicative, and had sent in required notifications. They were therefore no longer in breach of this regulation.

At our last inspection on 19 September 2017, we also found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we concluded that significant improvements have been made. However, further improvements were needed and those improvements made since our last inspection, had not yet been embedded in practice. Therefore the provider remained in breach of this regulation.

We saw that there were monthly room checks, which reviewed the safety of people's rooms and environments. These had been completed regularly but had not identified the hot pipes and heaters presenting a risk to people's safety. We saw that audits and checks were in place for aspects of health and safety, such as infection control. These were not always effective. For example they had not fully identified the concerns we had about the cleanliness of the kitchen and laundry storage. A regional manager's audit had not identified any infection control concerns in an audit carried out 27 February 2018. Therefore improved oversight was needed in terms of ensuring the quality of the service included infection control.

The manager had completed a full audit of people's care plans and identified gaps in these. They told us they were redoing all the care plans, starting with people they deemed most at risk. Whilst they were managing and coordinating people's care, not everyone's care records were accurate, complete and up to date when we inspected the service. The systems for monitoring and improving the service had not been fully embedded and sustained. Further oversight of the daily records including the daily care people received was needed, to ensure they received the care they needed.

Due to the timescale of the new manager starting in post in January 2018, we were unable to assess the sustainability of the improvements within the home since our last inspection. The manager had identified many shortfalls within the service and was working to improve these. We remain concerned that the provider had not made all the improvements required since our previous inspection in September 2017, in a timely way. Furthermore, the provider's audits had not identified all of the areas which remained in breach of Regulation.

The above concerns constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the concerns raised at our last inspection in September 2017, the providers completed a full audit in October 2017. They created an action plan to address concerns. Other representatives from the provider's organisation had visited regularly to work with the manager at the time to improve the service. However, action was not always taken in a timely way, which was identified in a further audit in December 2017. A further service audit carried out in January 2018 identified some improvements that had been made, for example in the care planning and provision of activities, as well as some areas where further improvement was still required. The provider was in regular attendance at the home to oversee improvements and support the manager.

People felt confident to approach staff and the manager, one saying, "If I have any concerns I tell the [staff] and they tell the manager." People told us they knew who the manager was, one telling us, "They come in and say hello."

Two relatives we spoke with felt that the home was trying to improve the quality of the service. The manager had made contact with them and had organised a meeting for people and their relatives.

There was a visible improvement in the leadership of the care shifts in the home, with staff demonstrating a more organised way of working within the home since we last inspected. One member of staff told us that shifts had improved and were running more smoothly, and that staff were aware of their responsibilities. Staff worked well together as a team. Staff told us that the new manager was approachable and proactive, communicating well with the staff team. One member of staff gave an example of a staff meeting where the manager had used scenarios to talk through staff knowledge, and encourage them to improve their practice.

The manager had taken appropriate action when they had identified concerns or staff raised concerns. We saw from records that the manager had taken appropriate disciplinary action when poor practice had been identified through observation and staff reporting it. This had led to improvements in the amount of incidences of staff misconduct within the home.

Staff told us they had confidence in the head of care and the manager. One member of staff told us, "I know action will be taken if there's anything." They also told us that staff meetings had been used for the manager to speak to staff about using their skills and find out about their knowledge. They felt the feedback from the manager was helpful to staff in their roles.

The manager was well supported by the care provider who was working in the home on a weekly basis. Staff also confirmed they felt the provider was approachable and there was an open door policy within the home. The manager was available to people and spent time around the home. People, relatives and staff confirmed that the provider and the manager had been visible within the home, and had been involved in improving care for people.

The home had been working with different external organisations to make the required improvements since the last inspection in September 2017. They had also sought external training to improve the competence of staff, who told us this had been effective.

Staff we spoke with had knowledge of whistle-blowing and reporting concerns, and stated the manager supported this practice.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care according to their needs and preferences. 9 (1) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care. They were at risk because staff had not always accurately recorded information related to risks consistently. Staff did not always mitigate risk as is reasonably practicable. There were infection control concerns in the home. 12 (a) (2) (a)(b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in places for monitoring the service were not always fully effective and had not led to timely improvements being made. Not all repeated breaches had been identified. 17 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to be fully responsive to risk and meet people's needs. Communal areas where people required support were not always supervised.

18 (1)