Solehawk Limited

Kenton Hall Nursing Home

Inspection report

Kenton Lane
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20 July 2018
26 July 2018

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 19 July 2018. This meant that the provider did not know that we would be visiting. We made a further two announced visits to the home on 20 and 26 July 2018 to complete the inspection.

Kenton Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kenton Hall Nursing Home can accommodate up to 60 people. At the time of the inspection there were 51 people living at the service, some of whom were living with a dementia.

The service was last inspected in August 2017. At that time, we identified a breach of the regulation relating to good governance. We rated the service as requires improvement. We asked the provider to complete an action plan to show what actions they were going to take to improve. At this inspection we found that although some action had been taken to address the previous shortfalls; we identified new concerns and shortfalls resulting in a continuing breach of this regulation and additional breaches of regulations 10 (dignity and respect), 11 (consent), 12 (safe care and treatment) and 18 (staffing).

A manager had been appointed in May 2018. They had applied to register with CQC as a registered manager. However, they left employment during our inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that care plans for people were not clear about the support people required and were inconsistent in the level of detail recorded. This resulted in care plans being confusing and containing contradictory material. Care staff delivered personalised care to people and had in-depth knowledge of people's needs but this was not reflected in the documentation we reviewed. In addition, some of the language used in care plans did not promote people's dignity.

There were shortfalls and omissions with the management of risk. Documented risk assessments were not always in place for identified risks such as diabetes.

Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 (MCA). The best interest's decision making process had not been consistently followed for people who lacked capacity to make certain decisions themselves.

Audits were detailed and carried out monthly. However, sometimes issues had not been resolved in a timely manner. Quality assurance systems had not been effectively implemented to assess, monitor and improve the quality of the service.

We saw positive relationships between staff and people. Most people spoke positively about the activities that were on offer.

We observed staff to show people warmth, compassion and kindness at times when they required support. Most people using the service told us they were treated with kindness and respect. Staff we spoke with thought the home was caring. A visiting professional spoke of a positive working relationship and that staff were always helpful.

Safeguarding procedures were in place and staff understood their role in how to protect people. Staff were knowledgeable about what to do should they suspect or have concerns about harm being caused to people. People told us they felt safe.

The service was clean and tidy and staff followed infection control procedures.

We received mixed feedback from people and staff regarding staffing levels and some staff told us they had too much to do. Safe recruitment procedures were in place. Some areas of training that the provider had deemed to be mandatory were not up to date. Some staff told us they did not have time to complete online training while at work.

The administration of medications was not consistently safe.

Following the inspection, we wrote to the provider to request an action plan which listed what action they had taken or planned to take to address the concerns and shortfalls identified during the inspection. We also referred all of our concerns about the service to the host commissioning authorities, Newcastle Local Authority and Newcastle Clinical Commissioning Group.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during this inspection 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 people were not always managed to make sure they received the correct care and treatment.

The management and administration of medicines was not consistently safe.

Safe recruitment procedures were in place.

The service was clean and good infection control procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not effectively met because of gaps in staff training. This included training the provider had deemed to be mandatory.

People's rights were not effectively protected because staff did not fully understand the implications of the Mental Capacity Act 2005.

People's dietary needs were not always met and we received mixed feedback on the quality of the food.

People were seen regularly by healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and independence was not always promoted by staff.

We observed practice that was kind and caring but we received mixed feedback from people regarding their exchanges with staff.

People reported that their relatives were welcomed into the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People spoke very highly about the activities co-ordinator and the activities which were on offer in the home.

People told us that call bells were answered in a timely manner.

Care plans were in place for people but were not consistently detailed. Some people did not have specific risk assessments in place for health conditions such as diabetes.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a manager in post at the beginning of our inspection although they were not registered with CQC. They left their employment during the inspection. The operational manager and a peripatetic manager were present throughout the inspection and were supporting the home both prior to and following the inspection.

Although audits were carried out monthly they were not robust and did not proactively identify that failures we found during this inspection. Where issues were identified improvements were not made in a timely and responsive fashion.

The service had continued to breach regulations from our last inspection.

Kenton Hall 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 was prompted in part by a notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management and risk of falls from moving and handling equipment. Those risks were considered when planning and during the inspection.

This inspection took place on 19, 20 and 26 July 2018. Our visit on 19 July 2018 was unannounced. This meant the provider and staff did not know we would be visiting. The second and third day of the inspection were announced.

The inspection team consisted of an inspection manager, two adult social care inspectors and a pharmacy inspector.

Prior to the inspection, we checked all the information we had received about the service including notifications which the provider had sent us. Statutory notifications contain information about certain events which the provider is legally obliged to report to us. We received a provider information return (PIR). A PIR is a form which asks the provider to give some key information about the service, how they are addressing the five key questions and what improvements they plan to make.

We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

During the inspection we spoke with 10 people who used the service and four relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. We spoke with the manager, peripatetic manager, regional manager, nine care workers, activity coordinator, one domestic staff, the cook and maintenance worker. A peripatetic manager is a manager who works across a number of services ran by the provider.

We reviewed seven people's care records. We looked at five staff personnel files, in addition to a range of records in relation to the safety and management of the service. We also spoke with two healthcare professionals who visited the home regularly. After the inspection the regional manager sent us further information which we had requested.

We also contacted one relative by telephone. We concluded these inspection activities on 30 August 2018.

Requires Improvement

Is the service safe?

Our findings

Medicines were not managed safely for people and the records for oral and topical medicines had not been completed correctly. For example, we found one person who self – medicated within the home who had been discharged from hospital with a new supply of medicines, however their current medicines administration record (MAR) was not updated with changes that had been made. Therefore, the home did not have oversight of this person's current medicines regime and could not monitor compliance if required. We were also told by this person that the home would take over supply of their medicines on the Sunday after our inspection, but on further investigation we found the medicines that were due to be started were still not correct as per the updated discharge instructions and there were eight discrepancies present. Medicines which required cold storage were kept in fridges within the medicines store rooms. The provider had a clear policy in place regarding temperature monitoring however this was not always followed by staff. Staff did not consistently record minimum and maximum fridge temperatures.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored and signed for when they were administered. However, staff were not following the provider's policy in relation to stock checks.

We looked at how the home managed topical medicines and found they did not have MARs for creams applied by care staff. We were told that staff completed sheets with a tick to show that creams had been applied but this did not tell us who had applied the cream, which cream had been applied or when. The home also did not have guidance in place with information for care staff on where or when to apply topical creams and there was a reliance on care staff knowing the resident. For example, for one person we found one cream in their room that was no longer prescribed and for another person, a cream that should have been discarded three months after opening but had no date of opening.

We looked at how the home managed application of patches to people and found they were not following their current medicines policy. For example, we looked at one person's MAR who was prescribed a patch for the treatment of dementia. This patch had directions to follow as per the manufacturer's instructions to help prevent side effects, however the home could not provide us with documentation to show this had been carried out.

We looked at the protocols for 'when required' medicines and found they were not always accurate and lacked detail to guide staff. For example, one person was prescribed four different medicines alongside each other for constipation. Each medicine did have a protocol in place however, none referred to each other and there was no guidance on when to give each medicine and on what occasion. A second person was prescribed a medicine for anxiety; there was no protocol in place and on further investigation this medicine had been administered twice to aid with sleep which was not as prescribed. Therefore, we could not be sure staff had sufficient information to administer when required medicine appropriately.

We also found one person who was prescribed a syringe driver (a device to administer medicine continually over a 24-hour period), had no care plan in place.

Care records included an assessment of potential risks such as falling and pressure ulcers. Risk assessments were in place for people who required the use of bed rails to prevent falls from bed. We found however, that one person's care plan and moving and handling risk assessment had not been reviewed following their discharge from hospital and change in their mobility. We read that another person received a pureed diet because of swallowing problems. On the second day of our inspection, we noticed that one person received a pureed diet. We observed however, that the mashed potato contained lumps and the peas had their skins on which could be a choking risk. We spoke with the operational manager who told us that this would be addressed and additional training in modified textured diets had already been arranged for kitchen staff. On the third day of our inspection, we saw that this person's pureed meal was the correct texture.

The provider's own auditing system had highlighted omissions regarding other risk assessments which the operational manager told us were being addressed.

This was a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Most people told us they felt safe. One person told us "I'm safe, completely safe." Another said "I feel really safe; the staff are excellent. The staff are the same every time I've been, they don't change their staff." A third person raised concerns about the attitude of a member of staff. We raised this with the operational manager who told us they would speak with the person and investigate their concerns.

Safeguarding procedures were in place and staff understood their role in how to protect people. Staff had a good understanding of safeguarding procedures and what action they needed to take to escalate any concerns.

There were mixed responses from people about staffing levels. Comments from four people included; "It would be better with more staff," "They [staff] come quickly when I press the buzzer," "More staff available would be good to take the weight off the staff. Despite the pressures, they still make time to spend with me," and "Sometimes you can't find staff and sometimes they all go out together." The manager told us there had been times where the service had been short staffed. Since they had come into post, they had started the recruitment process to employ more staff.

Accidents and incidents were documented; however, there was no thorough analysis to determine if any trends could be identified or if any further steps could be taken to reduce the risk of accidents reoccurring. The provider had falls analysis documentation to be reviewed on a monthly basis. We found consistently that this documentation was blank and there had been no analysis of falls.

This was a breach of Regulation 17 Heath and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

People were protected from the spread of infection. The home environment was clean with no malodours. The provider had appropriate infection control measures in place. Personal protective equipment such as gloves and aprons were available to staff and hand sanitizer was also available throughout the home. We observed staff making use of this throughout the inspection.

We checked the safety and suitability of the premises and equipment. Checks were carried out to make sure that the building and equipment were safe. Personal evacuation plans were in place which detailed the support people would require to evacuate the building in the event of a fire at the home.

The home was accessed via a coded security door. On the first day of inspection the inspection team were given access to the building without being asked who we were or checking the purpose of our visit. We also observed relatives allowing others access to the building and the main door being left open. We judged this to be a security risk and brought this to the attention of the manager and peripatetic manager.

Safe recruitment procedures were followed. Staff files contained a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. References and DBS checks were in place before staff had started work. Checks were in place for nursing staff to monitor that their registration was up to date. Nursing staff are required to be registered with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2017, we rated this key question at 'Good'. At this inspection, we found the provider was not adhering to the principles of the Mental Capacity Act. We also found that staff had not received training in key areas of their practice, including safeguarding and risk assessing.

The provider had identified a schedule of training which they considered mandatory for staff. In June 2018 the providers audit showed that training compliance was below 50%. An action plan had been developed to address this and in July 2018 overall compliance with training was 71%. The providers records show that training gaps remained. At the time of the inspection 7% of staff were trained in assessing risk, 34% trained in safeguarding, 47% of staff trained in fluids & nutrition, compliance with Mental Capacity Act and deprivation of liberty training was 52% and moving and handling 71%. Condition specific training had not been provided to staff to help them meet the needs of the people they were caring for.

During the inspection, we identified omissions and shortfalls regarding the MCA, assessing risk and fluids and nutrition.

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

The provider had identified a minimum standard that staff must receive six formal supervision sessions per year. The manager told us when they began working at the home in May, supervisions and appraisals for staff were not up to date. The manager had a plan in place for staff supervision sessions to be planned for the remainder of the year. We saw the supervision and appraisal matrix which recorded when supervision sessions for staff had taken place. Staff told us they did receive supervision and felt supported by the manager.

Staff felt supported and felt that morale at the home had improved. Staff attributed this improvement to the manager of the home.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty 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 Deprivation of Liberty Safeguards [DoLS]. Some people who used the service did not have capacity to leave the home unaccompanied as it had been assessed they would be unable to keep themselves safe.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw applications had been made to the local authority for assessment regarding DoLS authorisations for people considered to lack mental capacity.

We saw records in some care plans which showed people and their relatives had been involved in decisions regarding care and treatment. However, in other care plans MCA assessment documents were blank or staff had not completed assessments due to being unable to communicate with the person. We did not see that the best interest's decision process had been consistently followed for people who were unable to make decisions for themselves. There were examples where relatives or carers had signed consent forms without checks being carried out to confirm if those people had the legal right to make decisions on the person's behalf.

Lasting Power of Attorney (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future. There are two types of LPA; those for financial decisions and those for health and care related decisions. We asked the manager how they knew if a relative or carer had the legal right to make decisions on behalf of a person who lacked capacity. The manager told us there was no central list within the home which detailed who had a LPA. The manager said she thought a relative had legal authority to make decisions for their family member as they visited every day. This meant any consent given by relatives assumed to have LPA could not be confirmed as appropriate proof was not available. We brought this to the attention of the manager who agreed there was a need for staff training.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback on the quality of the food. People's comments included "Excellent food, I enjoy all of it," "You don't get the salad, it's printed on there [the menu] but they don't give it. The soup is not very nice, it's either got too much pepper or no salt but sometimes you can't work out the flavour," "On a Friday there is always a choice of fried fish or steamed fish but there's not much choice on a Friday tea time for people who don't like fish" and "I don't think the kitchen taste the food before they send it as it doesn't have salt and if they tasted it they'd know, people just leave it. The chef makes scones and things and they are good."

We observed the lunch time dining experience in different parts of the service. Some people had chosen to eat in their bedrooms while others ate in the dining areas of the home. We found that staff supported people differently and some practice was task orientated with little interaction with people. There was a delay in serving food and drinks to some people and observed that staff would switch between people to offer support. One person who was waiting to be served food while others around him had received a starter and main course told us "I've got no patience really I feel like walking out, I need something to drink as well". We spoke to the operational manager about this and observed the meal time experience on the second and third day of the inspection to be improved.

People's dietary needs were not always met. People who were assessed as requiring specialised diets such as a soft or pureed consistency did not always receive food in this way. We observed that one person who's care plan documented they required a pureed diet received a meal which contained lumps and peas with skins on. One member of staff told us "the pureed food is lumpy sometimes". We saw another care plan which recorded the person required stage 2 thickened fluids. Thickened fluids are recommended for some people with swallowing difficulties after an assessment by a speech and language therapist. Their care plan

file contained a letter from a Speech & Language Therapist which recorded the person required stage 3 thickened fluids which was contradictory to what was documented in the care plan. This placed people at risk of harm due to the potential of choking.

Developing risks were not always noticed or reacted to in people's care plans. We saw some care plans documents that were blank where assessments had not been completed for people. One person's care plan identified they required a weekly weight to be recorded and be given high protein drinks twice per day due to weight loss. We saw records that showed weekly weights had not been taken and high protein drinks were not being offered to the person as documented in their care plan. This person had lost weight and placed them at risk nutritionally. The peripatetic manager told us that a new weight monitoring form had been introduced which would record weekly and monthly weights separately. However, nurses we spoke with were not aware of this new system. The short falls with risk assessments had also been identified on the provider audits.

There was no clear system in place to monitor fluids for people who had daily targets for fluid intake. We saw records that consistently showed people had not achieved their daily target amount of fluids. Care records did not show what action had been taken to ensure that people did not become dehydrated if they had not consumed enough fluid.

People told us and we saw in care records that people had access to healthcare professionals. A visiting professional to the service told us of strong links between the home and the GP practice. We received mixed feedback from visiting professionals. One told us "I'm quite confident here, it's a busy round but the nurses put people down who need to be seen. The nurses are good at recognising when someone needs additional support and basic nursing care is good. Staff know residents well". Another visiting professional said, "In my experience care plans are poor and documentation is not reflective of risk". A person living at the service said, "They are very good getting the doctor".

Requires Improvement

Is the service caring?

Our findings

Most people using the service told us they were treated with kindness and respect. One person said, "Oh very caring here, they can't do enough for you". Another person said, "We have some very special staff who are lovely with us. I know all of their names". A third person told us "I don't call them carers any more, I call them friends". A relative told us, "I couldn't fault them. They are lovely staff. She [person] knows them all because they speak with her and she knows their voice". Another relative showed us a photograph of a night staff member smiling at their relation and said, "Look at the way he is looking at dad, he is a carer who cares".

However, we did get less positive feedback from two people living at the home who raised concerns about the attitude of one member of staff. We brought these concerns to the attention of the operational manager who gave an assurance that they would speak with the person and investigate.

Staff we spoke with told us they thought the home was caring but that they didn't always have enough time to spend with people because of the amount of work to do. We observed throughout the inspection positive interactions between staff and people.

We observed staff to be friendly and offer reassurance to people when needed in a kind and compassionate way. Staff had caring attitudes and we saw instances where staff responded quickly to people's needs. In conversations with staff they told us ways in which they considered how to treat people with dignity and respect when supporting people with personal care.

However, some of the language used in some care plans did not promote people's dignity. For example, some care plans referred to people requiring 'nappies' rather than using the term continence products. Another care plan referred to a person living at the service as 'dumb' to describe they could not communicate verbally. The manager felt that this was due to English not being the first language of some staff. The manager told us "Care plans aren't as person centred as I want them to be sometimes because of language. Staff are caring when you speak to them but it doesn't always translate well into written English". The manager had identified these issues and we were told there was a plan in place to update the language in care plans.

Some people told us they were unable to have a bath or a shower every day if they wanted to. These people told us that unless they were supported to get up in the early morning by the night staff they could be waiting until mid-morning to get dressed and have breakfast. They told us this was because there were not enough staff in the mornings. One person told us they did not feel their dignity was respected. They said, "Two is what we get [showers per week]…I have two bowls [to wash] it's so degrading sitting on the commode. I have no dignity". Another person told us, "You are supposed to get two showers a week but it doesn't always happen as they are short staffed. When this happens, I get a wash down on the bed but it's not the same". We shared these comments with the operational manager who agreed that people should be able to have a bath or shower when they wanted one.

This was a breach of Regulation 10 Heath and Social Care Act (Regulated Activities) Regulations 2014. Dignity and respect.

There were four married couples living at the home and consideration had been given to support people to maintain their relationships. We were told that none of the couples had chosen to share bedrooms but that if they wished to this would be arranged.

There were a number of people living at the service where English was not their first language. Some staff told us how difficult it was to communicate with these people and that they relied on relatives to translate during visits. One staff told us that at times they had used the internet to translate language to allow them to communicate with people. One member of staff told us "It's really bad. It's frustrating. The menus need to be in different languages too".

Some information had been provided in accessible formats to help people understand. However, translation services had not been used which meant that people were not fully involved in their care. On the second day of the inspection we brought this to the attention of the operational manager. On the third day of inspection the operational manager updated us that two iPads had been purchased and google translate software had been added to them. Staff were now able to speak into the iPad and the computer would verbally translate this into the selected language. The operational manager told us "[Name of person] face really lit up when we communicated with [name of person] and [name of person] then began to also speak a bit English. [Name of person] was very animated and happy. This has really had a positive impact and staff are happier they have all been shown how to do it and feel more able to meet [name of person] needs".

Advocacy services help people to access information and help people to be involved in decisions about their lives. One person we spoke with told us that they had an advocate who helped them to speak about issues that were important to them.

People's religious beliefs were recorded where appropriate. Staff were respectful of people's cultural and spiritual needs when these were known. One person was supported to pray in their room during the day. However, due to language barriers staff did not always know what people's preferences were.

People's confidential information was stored securely and could be located when needed. This meant that people's confidentiality was maintained as only people authorised to look at records could view them.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at differed in quality and were variable in the amount of person centred information included. Person-centred planning is a way of helping someone to plan their life and support, focusing on what is important to them. However, some care plans were limited in information about people's likes and dislikes or contained contradictory information. We also saw some care plans had not been reviewed following a change in a person's need. For example, a care plan was in place for a person who had a long-term health condition. There was no information included in this care plan to guide staff on how to manage the condition and what to do should certain symptoms become present. Another care plan identified a person was at risk of pressure damage. However, the care plan was not detailed in specifying how often the person required positional changes throughout the day or what action staff should take if pressure damage to skin occurred.

One family member told us that information shared at a pre- admission assessment meeting had not been included in care plans for their relative. Therefore, we could not be sure there was sufficient information to guide staff in certain aspects of people's care.

We saw one care plan that was detailed and contained a lot of person centred information about the persons religious beliefs. This care plan contained detail of how the persons cultural needs should be met.

There was limited evidence of a timely review of care plans. It was not clear from the detail recorded that appropriate action had been taken in all incidents. This meant that important information could be missed. We did find that daily notes for people were more comprehensive and contained more detail.

We checked how people's social needs were met. The service employed a full-time activities coordinator who worked from Monday to Friday. People and their relatives spoke highly of the activities co-ordinator and the activities that were available in the home. Social events were also organised and preparation was in progress for an annual summer fayre. There was a dedicated activities room on the first floor of the building which was filled with examples of people's art and crafts. We saw a memory book which had been created which contained photographs of people engaged in activities. The themes of activities included 'Fun in the Sun', 'Caribbean Day', 'Cocktails', 'Sports Day' and 'Mastermind Challenge'. One person told us "We have a very good activities side, we do arts and crafts". Another person told us "Oh yes [there is plenty going on]. There's painting, colouring in and I won twice on the bingo".

A volunteer into the service told us, "[Name of activities coordinator] is a superstar". A relative of a person living at the home said, "The activities co-ordinator is fantastic". However, one relative told us there were no activities available to people with complex needs. We observed periods throughout the inspection where some people were not engaged in any meaningful activity. We carried out observations in the communal lounge and saw no interaction between staff with some people who were unable to communicate verbally. We did not see any sensory activities available to these people during the inspection. One person told us "There is enough going on for those that like arts and crafts. I can't stand bingo or arts and crafts. They have bus trips, but I can't get on. I miss out on a lot of things". We raised these comments with the operational

manager.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way the can understand. A number of people living at the home did not speak English. We were told some staff had basic skills in other languages however, some staff told us how difficult it was to communicate with people who did not speak English. We saw one example of staff using their own initiative and using technology to communicate with a person where English was not their first language. The operational manager responded to this and purchased two iPads to be used to communicate with people across the home. After positive feedback from staff of how this had been a supportive tool we were told by the Operations Manager and the Peripatetic Manager that they would access more iPads to ensure this practise was extended to the first floor.

We looked at how the provider managed complaints. There was a complaints procedure in place. People and relatives told us they knew how to raise a concern or make a complaint. One person said, "I would rate it 'perfect'. I have no complaints whatsoever". A relative told us, "We have complained, but everything slides back". We saw complaints had been documented but it was not always clear from records what action had been taken. We saw one complaint made by a visiting professional. They raised concerns over a number of weeks that toileting slings were being used for all transfers for people who needed to be hoisted. No action had been taken, therefore the complaint was escalated to the operational manager. Action was taken on the same day to address this and an investigation commenced to identify why the previous manager at the time had not responded to this complaint and taken any action.

We saw compliments had been received. Comments included, "Thank you for all you did taking care of [name of person]. You made their last years comfortable". Another compliment said, "Special thanks to both day and night staff for looking after me while I have not been well".

There was no one receiving end of life care at the time of our inspection. Care files contained limited information about people's end of life wishes. One care plan recorded that a person's family did not wish to discuss end of life care. However, there was no evidence that the person themselves had been consulted.

Requires Improvement

Is the service well-led?

Our findings

When we completed our last inspection in August 2017 we rated this key question as 'Requires Improvement'. The provider was in breach of Regulation 17: Good governance. The provider's quality monitoring system had failed to identify and address issues which were found during the inspection. Following the last inspection, the provider identified an action plan to address the specific issues we raised.

During this inspection, we found continuing serious concerns and shortfalls relating to the governance of the service.

There had been changes in the management of the service. The previous registered manager deregistered from the service in May 2018. A new manager had been appointed in May 2018. People, relatives, staff and most health care professionals spoke positively about the manager and the changes they had started to implement. A person living at the service told us "[Manager] has made changes – she got us decent mugs". One staff told us "The manager is lovely", another said, "Anything you need she [manager] gets". A relative told us, "We have just got a new manager and she has done a lot". A visiting professional said, "In my opinion things have improved since the manager changed. Morale has lifted too". The manager was not present on the third day of inspection and was no longer employed by the end of our inspection. The provider assured us the peripatetic manager would provide management cover into the home until a new manager was recruited.

The operational manager visited the home on a regular basis and the peripatetic manager was also providing support. A range of audits were undertaken within the service. Audits were detailed and carried out monthly, however sometimes issues had not been resolved in a timely manner. For example, audits had raised concerns about care plans and risk assessments however, we identified ongoing concerns with care documents.

We found that information recorded in people's care plans lacked detail and was not always up to date. The best interests' decision process had not been recorded consistently for people living in the home. We also found that people's capacity was not being assessed or recorded in a consistent and clear way. This exposed people to a risk of abuse of their rights. A 'Resident of the day' scheme had been introduced. This meant that one person, on most days, was chosen to have their records checked. We spoke with staff who explained there was insufficient time to complete paperwork, more staff were required and there was a lot of duplication of records.

We saw a food and mealtime audit which had identified that people were not involved in planning menus and no system was in place for people to comment on food and the meal time experience. The audit also identified that food and the mealtime experience were not discussed at service meeting. No action plan was identified in this audit of how these issues would be addressed by the provider.

We looked at the processes for auditing medicines within the home; whilst the most recent audit had picked up some issues, there had been no action plan put in place to address them. The audit had failed to pick up

the issues we found during this inspection.

We found that the provider's quality monitoring system had failed to identify and address the issues which we found during this inspection.

This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The provider used surveys to seek the views of people who lived in the home, visitors and staff. The manager held 'resident and relatives'' meetings and also held staff meetings where agenda items were discussed. The manager told us the survey results had not been positive. We were told that a monthly action plan was in place to make improvements within the home.

The home continued to have good links with the local community. The activities coordinator has maintained relationships with a number of organisations including a local garden centre who visited yearly to facilitate a session with people to make hanging baskets to display around the home.

Award systems were in place by the provider to show staff they were valued. A 'wall of praise' contained notes of thanks from people and relatives. One person had written a note which said, "Special thanks to both and day staff and night staff for looking after me while I have not been well". The provider also had the 'star of the month' and 'golden ticket' award schemes. Throughout the month people and visitors were encouraged to complete 'a big thank you card' to nominate staff who they thought had excelled in their work. Department heads could also nominate staff. Winners were decided on the strength of the achievement and not the number of nominations. Staff who won these awards were rewarded with a financial gift.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3).

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 Not all risks had been assessed or action taken to reduce the risk of harm. Medication was not consistently safe. Regulation 12 (1)(2) a)(b)(c)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system was not fully in place to ensure that staff received appropriate training to enable them to carry out their duties they were employed to perform. Regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to health, safety and welfare of people who used the service. Regulation 17 (1) (2) (a) (b) (c) (d) (i) (ii) (e) (f).

The enforcement action we took:

Warning notice