Mrs Lalitha Samuel

Friars Hall Nursing Home

Inspection report

Friars Road
Hadleigh
Ipswich
Suffolk
IP7 6DF

Tel: 01473822159

Date of inspection visit:
10 August 2016
11 August 2016

Date of publication:
06 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 August 2016 and was unannounced.

Friars Hall Nursing Home provides accommodation and support to older people and those with physical disabilities and dementia. The service is registered to provide the regulated activities of accommodation for people who require nursing or personal care, treatment, disease or injury and diagnostics and screening procedures. The service can accommodate a maximum of 54 people. On the days of our inspection there were 43 people using the service.

There was not a registered manager in post at the time of our inspection. The new manager was in the process of seeking registration with the Care Quality Commission (CQC).

A registered manager is a person who has registered with 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.

At our last inspection on 3 June 2015 we found a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had failed to establish and operate an effective and accessible system to receive record, handle and respond to complaints made by people using the service The provider sent to us an action plan telling us how they would make improvements in order to meet the relevant legal requirements.

At this inspection we found the provider had taken sufficient action to meet this legal requirement.

However, during this inspection we found other areas of concern.

We found that staff were not recording accurately the care provided to people with continence needs with regard to recording when leg bags attached to catheters were changed. We also found that re-positioning charts for people were not being completed as per their care plan. Hence we could not be sure when people were being repositioned sufficiently often enough to reduce the likelihood of pressure sores. We could not be sure from the records one person whether a pressure sore they had developed was being cared for properly.

We were not confident that medicines were being managed properly. This was because medicines had not been correctly booked into the service. Also we found that a medicine had been signed for in the Medication Administration Record (MAR) to state that it had been administered when in fact it had not.

People were not always being protected from abuse. On the day of our inspection the service did not have any sterile dressings, which meant that one person's dressing change due that day was not done. The

Clinical Lead did raise this as a matter of safeguard at the time with the relevant authorities and ordered a new supply which was with the service the next day.

The premise was not secure. One person had tried to leave the service and actions regarding security had been taken downstairs, but the window restrictors upstairs were ineffective and meant that people would be at significant risk of falling if they tried to leave the building that way.

The service had no processes in place to check that equipment such as the suction machine and syringe drivers were being checked as in good order and fit for use.

Although staff considered there were enough staff on duty. The management were not aware of how many people at the service required nursing care and there were no completed dependency assessments of people's needs being carried out to determine number of staff required to be on duty.

The service had emergency plans in place and monitored accidents that occurred to determine any correcting action that could be taken. The service had a system in place for recruitment. However we could not be assured that an on-going training and development plan had been organised for nurses to continue to keep up to date with their practice. The new manager and clinical lead had been in post for four months and had not commenced any supervision or appraisals for staff. However, we understood from the clinical lead that they had reviewed the situation and were in the process of implementing a programme of planned supervision in the near future.

The meals we saw on the days of our inspection were appetising and we saw staff supporting people with their meals. We saw staff being carrying towards people and some staff knew people well. People told us they had good relationships with the staff. However, there was no robust system in place to ensure the catering team were aware of people's dietary needs, in particular people with diabetes.

People told us they enjoyed the activities provided, but when staff were on holiday, others did their best but they could become bored with the lack of activities.

The service worked with other professionals but we were surprised to see the level of support that the service required from other professional nurses as the service is registered for nursing care and does employ qualified nursing staff.

The care plans lacked detail with regard to the mental capacity of people and how care was to be provided. We were informed by the clinical lead that they were being reviewed and saw this was in process.

The quality of recording was not always adequate. Records failed to demonstrate that people were receiving the care they needed. There was inadequate management oversight of the service. The manager and clinical lead had been unaware of the concerns identified during our inspection until these were outlined during feedback. Although the manager was not present during our inspection, we could see no evidence they were aware of or had taken action to address these short-falls in the service provision. Some areas of the service were audited periodically but there was no service improvement plan in place to address any shortfalls identified. Although the provider was present most days at the service they did not carry out or record monitoring visits to the service.

The auditing of the service was lacking in detail and action. Although medication audits were in place they were not followed up from one month to the next. Hence, instead of being an auditing process for safety and improvement, the documents we saw were stand-alone documents.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Medicines were not administered safely as prescribed.

The environment was not safe with regard to window restrictors and equipment such as suction machines and syringe drivers being checked as fit for purpose

Care and treatment was not always provided in a safe way, the service had no sterile dressing on the day of inspection and a dressing that was due to be changed that day was not done.

Is the service effective?

Inadequate

The service was not effective

Staff were not receiving supervision

Some aspects of the Mental Capacity Act were being correctly implemented while others were not.

The service was not accurately recording the diet and fluid intake of people.

People were not being referred for professional support as appropriate depending upon their condition.

Is the service caring?

Requires Improvement

The service was not always caring

We saw staff acting in a kind and compassionate manner

People were given time to express their views

People's privacy was respected

However as care was not always provided in a safe way and several concerns were identified which left people at risk the provider overall was not caring in their approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans were not regularly reviewed.

There was a compliant system in operation

Is the service well-led?

Inadequate

The service was not well managed.

The service was not carrying out effective audits.

Care plans were not being regularly or effectively maintained or reviewed.

Information was not being effectively communicated.

Friars 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 10 and 11 August 2016 and was unannounced. The inspection was carried out by one inspector, a specialist advisor and an expert by experience on the first day and two inspectors on the second day.

An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had recent professional experience in the management of nursing care.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The service had returned a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Some people had very complex needs and were not able, or chose not to speak to us. We used observation as a tool to gather evidence of people's experiences of the service, including in the dining room during lunchtime. We 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.

During the inspection we spoke with seven people and five relatives. We spoke with the provider, clinical lead, two registered nursing staff and an agency member of staff, one senior care assistant, two care assistants and the chef.

We looked at the care records of seven people, including risk assessments. We looked at how medicines were managed and the records relating to this. We looked at three staff recruitment files and records including training provided. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service

Inadequate

Is the service safe?

Our findings

People at the service were not safe because they were not protected from the risk of harm.

We looked at the wound care records for a person using the service. The current plan stated that the dressing should be changed every '2/3 days'. The last entry on the form was dated 6 August 2016, four days prior to our inspection. We asked two nurses when the dressing was due to be re-newed, they both said it was in the care plan. Once they had checked the care plan, we were informed the dressing would be done today.

One of the nursing staff showed us where the dressings were stored. There was a range of dressings in boxes. On checking expiry dates of the dressings, these were out of date Sorbsan, Mepore and some gauze packs. We advised the nurse to check all of the other dressings for their expiry dates.

We asked if there were any more sterile dressing packs as the packet was empty, they looked in the cupboard, there were none. We enquired if any were stored elsewhere. They did not think there were and so we asked the clinical lead if the service had any more sterile dressing packs as there were none in the store cupboard. They confirmed there were no sterile dressing packs in the service.

This is unsafe practice not to have sterile dressing packs to carry out wound care, the service had no equipment available to complete the person's dressing that day.

The failure to change the dressing as prescribed is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users.

The Clinical Lead raised this as a matter of safeguarding at the time with the appropriate authority and ordered dressing packs to come to the service the next day. However, this meant that it was five days since the person's sacral wound has been redressed. If the dressing became unsecure, the risk of infection in the wound was high. The clinical lead on duty who told us that the ordering process for dressings was not robust and would take action to correct. We explained that service users in the care of the service must be protected from abuse and improper treatment. As the treatment had not been provided for 5 days this was abuse.

This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguard service users from abuse and improper treatment

The environment was not safe. We noted that the restrictors on the upstairs sash style windows were not sufficient to prevent people climbing or falling out of the windows.

During the inspection the clinical lead told us about an incident when a person attempted to leave the service via open doors and windows downstairs. Action had been taken on the ground floor to keep the

person safe and prevent them leaving the building, but the windows upstairs had not been checked. This was an example of when the risk described above had a direct impact on people using the service.

We observed equipment at the service including suction machines and syringe drivers which were not being checked as fit for purpose. We asked a nurse and the Clinical Lead if regular checks were completed on this equipment, the Clinical Lead said the records for this were in the orange folder, we looked at the folder, this only contained the records of the room and drug fridge temperatures, these were within normal range. However this meant that the equipment was not being checked regularly.

This is unsafe practice, if equipment is not checked regularly and any faults or missing equipment is not reported and managed, in the event of an emergency it may not be ready for use.
This meant that if people needed the use of this equipment, it may not be in a useable condition and would put people at risk of harm.

This is a breach of 15(1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All premises and equipment used by the service provider must be properly maintained.

It is important for people's well-being that they are provided with the medicines that have been prescribed for them at the correct time and this is accurately recorded. Records that are unclear can lead to errors happening and have a direct effect upon the person's well-being.

Medicine was not consistently safely managed. We observed nurses administering medicines and saw that they did this with a compassionate and caring attitude. They individually dispensed people's medicine by referring to the medicine chart. The drug trolley was kept secure at all times. We observed the nurse telling a person about their medicine.

However, at 11.45am we saw the Medicine Administration Record (MAR) chart for one person recorded that their prescribed regular medicine had been administered at 12.00pm as the MAR chart had been signed.

We asked the nurse if the person had been given their medicines. They replied, "No, I haven't," We asked why had they signed the MAR chart. They did not give us an answer.

Signing before administering a medicine is confusing for other staff involved with the administration as they cannot be sure the record is accurate. Not following the procedure for administering medicines at the set time is potentially dangerous with a serious impact for the person, because there is no clarity regarding what medicines they have or have not received and some medicines are required to be given at specific times.

We looked closely at other MAR charts. We found four medicines, some of which were controlled drugs to be incorrectly recorded on the MAR charts and did not follow the services own policy and procedure.

We consistently saw that medicine that was transcribed was not double checked by another nurse as set out in the service policy and procedure. Where medicine had been prescribed this had then been added to from medicines brought from home. However, this was not the same prescription dose. Therefore nurses would have been unclear as to what dose to administer. The MAR chart remained the same, but labels on medicines were different. This was specifically two boxes of the controlled drugs Diamorphine and three bottles of Morphine Sulphate Oral Solution that had three different instructions. Whilst Inspectors were present some medicines were destroyed to make the situation safer as those could no longer be used, but some were needing further clarification to ensure the correct dosages were known and available for

administration therefore the clinical lead agreed to seek further medical advice about the prescription.

The matter of transcribing medicines by one nurse was also questioned in relation to a medicine called Zomorph. We saw that the home had ran out of 60mg tablets so was administering two 30mg tablets instead. This initially appeared to ensure the person was receiving medicines as intended. However, they were also receiving 10mg tablets as well. We were told that the intention of the prescriber was for the person to receive 80mg twice a day. But this was not clear as the MAR chart had been handwritten by one nurse and there was no other evidence available to verify this.

Medicines that when administered required being sited on a different part of the body from the previous administration should be recorded on a body map for the person. We saw that this was not being done consistently for the person.

When administering medication patches it is important to record on a body map when the patch was applied and to which part of the body it is was applied to. Accurate record keeping means that when a new patch is applied it can be positioned onto a different part of the body.

Failure to record where the patch was administered meant that the next patch could be applied to the same area and this could cause irritation to the person's skin. Hence the recording must be accurate.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The proper and safe management of medicines.

We noted there was no record of/or plan in place to change the catheter leg-bags of one person using the service. This meant that for this person they were exposed to a greater risk of acquiring an infection.

The Association for Continence Advice (2007) suggests that reusable drainage bags are changed every five to seven days in accordance with manufacturers' recommendations and Department of Health guidelines.

Repositioning charts for two people were not clear, hence we could not be assured that care was being provided safely and appropriately to alleviate pressure sores from developing.

The repositioning charts were not being completed accurately. We saw over a 24 hour period that one person had been repositioned after 6 hours and also after 1 hour. The care plan was clear that the person needed repositioning but did not instruct how often the person was to be repositioned. This left the person at a higher risk of developing a pressure sore. Regarding the repositioning of another person, the chart in their care plan was not named or dated. It did record position changes, but there was no information concerning the frequency required.

It is important to determine if someone needs support with repositioning, how frequently this should be done and to be accurately recorded. If the person is not re-positioned, there is a greatly increased risk that they will develop pressure sores.

We were concerned with the care provided to one person and could not be confident from the irregular timing of photographs being taken if the staff had recognised they had a pressure sore.

Failure to accurately recognise a pressure sore will mean that treatment will not be provided as soon as required to prevent deterioration and aid recovery.

We looked at the wound care plan for a person and it was unclear, as no measurements had been taken of the wound or clear instructions concerning the dressing used. There was no plan to say how frequently photographs were to be taken and the last one we saw was dated 31 July 2016. As there was no measurement or regular photographs we could not be sure if the wound was improving or not.

This is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users.

One person told us. "I feel safe because there were staff around and they responded quickly when I call." A relative told us, "I am confident that the staff made sure that my [relative] is safe and well cared for." Another relative told us, "Staffing levels are usually adequate."

However, we looked at the staff rota for both day and night duty and saw they the number of staff on duty was consistent. We also saw assessments of need in the care plan but this information had not been used to complete a dependency tool to determine the number of staff to be on duty with regard to the complexity of people's needs throughout the 24 hour period. The senior staff were not able to tell us how many people required nursing care or residential care.

On one occasion, we heard the call bell sounding for 23 minutes without stopping. One person living at the service was distressed by the loud sounding and repeated asked for it to stop. We raised this and the provider said they had noted this as well and looked into it. They had found that staff had been moving from one call to another and as one was answered another would be activated. We asked for a print out of the system to corroborate this, but were told that there was not the correct type of paper for the printout so it was not available.

We recommend that the service seeks advice with regard to how it can effectively monitor the time of each call bell from activation until a member of staff attends to the person. This will help the service to establish if there are sufficient numbers of staff on duty.

The dining and sitting room on the ground floor was the focal point for both meals and organised activities. However, environmental hazards were observed in the dining room. Due to the position of four large dining tables wheelchair users experience difficulty negotiating around the room.

These rooms were used as a circuit for people who chose to keep moving and walk around, however because of a discrepancy in floor levels between the sitting room and dining room, a ramp was in place. People with mobility problems experienced difficulties negotiating the ramp's uneven surface.

A red brick fireplace hearth was considered to be a trip hazard to people because of the raised edge and there were no visuals warnings in place.

We found a mixed picture in relation to risk assessments to protect and support people. We found some areas where there was good practice, but others that potentially placed people at risk. We concluded that the service was inconsistent in their approach to risk assessment.

We looked at one person's care plan who had fallen recently. We saw that an accident record was completed. We saw that a good record was made of the incident itself, recording of the monitoring of that person for some time after the event. This showed us that the nurse on duty not only ensured how the person was after the initial event, but that they checked them for any symptoms that may have later developed. We also saw for this same person that risk assessments for skin integrity such as waterlow and

nutrition risk assessments were completed as was required. These had regularly been reviewed by a nurse. This person also had a moving and handling risk assessment in place that clearly guided staff about equipment to be used; which hoist to be used, the sling type and the size of sling to be used for the individual.

We understood from talking with the Clinical Lead that the new management team were reviewing the care plans which included risk assessments. We would like to have been assured of a timeframe by when all the care plans and risk assessments had been reviewed but appreciated that this work had commenced

We looked at the recruitment policy and process used by the service. The files we examined recorded that potential applicants were invited for interview and successful applicants were provided with a job description and contract of employment. Before the employment commenced peoples references were checked including ensuring the person had clear record with the Disclosure and Barring Service (DBS) to confirm they were safe to work with people using the service. We saw that when one applicants reference despite repeated attempts by the service to contact them was not forthcoming. Before employing the service had sought two additional satisfactory references.

Inadequate

Is the service effective?

Our findings

People who used the service were not receiving care from staff that were being appropriately supported. All the staff we spoke with told us about the training they had received. One staff member told us, "The adult safeguard training was very good." Other staff members including the qualified nurses had attended training on various topics. Staff members explained that training took place on site, and was organised to take place at different times of the day.

However, we were made aware that at the time of our inspection there was no supervision being provided although the provider had a policy and procedure for doing so. In fact staff interviewed did not appear to understand the concept of supervision and described this as a managerial and not a professional development tool. The manager and clinical lead had been in position for over four months and had not provided any supervision as yet. The clinical lead told us that this was being planned as were annual appraisals and would commence soon.

We saw that the nursing staff were up to date with maintaining their professional practice regarding their pin number. The Nursing and Midwifery Council (NMC) is the regulator for all nurses and midwives in the UK. When nurses register with the NMC, they will be given a pin number. Without that pin number you cannot work as a nurse or a midwife in the UK. However, we were unclear the action the provider would take to support the nurses with regard to the nurses revalidation process with the Nursing and Midwifery Council.

This is a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Persons employed for the purposes of carrying on a regulated activity must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

We saw that the service was assessing people's capacity with regard to 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 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The clinical lead explained to us how the people had been assessed with regard to MCA and DoLS and we saw that appropriate documentation had been completed and submitted to the appropriate authority for DoLS.

In one care plan we saw that the person had been appropriately assessed in relation to managing their own medicines. An assessment that followed the principles of the MCA had been completed and the service were confident that the person had the capacity to safely manage their own medicines. However, upon further investigation it became clear that this had not been frequently reviewed and was no longer the case as nurses now managed their medicines.

The service had assessed one person's capacity in regard to their need for covert medicines. But, we saw in one care plan no assessment for MCA and in another one was partly completed with regard to the support the person required with their continence.

We saw an MCA 1 form was completed on 19 June 2015. This form records that the person bit the cover of their air mattress on 5 June 2015 and recorded '[this person] is therefore being nursed on a foam mattress.' This was reviewed on 25 August 2015 and states 'No changes.' There were no further reviews recorded or the MCA forms updated.

This is a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment of service users must only be provided with the consent of the relevant person.

The lunch time experienced for people who used the service was varied, and people had differing opinions regarding the meals provided.

On person stated that, "Not sure what it was; it was a bit chewy. It's not good at the moment but they're just starting up." Another person told us, "The food is good." They said that they were given a good range of choices, and encouraged to eat. They told us that the catering had staff offered to make them a scrambled egg on toast at suppertime when they were unwell.

A relative told us, "They offered to make [my relative] an omelette when [they] refused to eat [their] tea. "[They] loved that." This confirms that staff attempt to ensure that people's nutritional needs are being met.

However, while people were sitting in the dining room after their meal, linen soiled during the meal was collected and placed in a linen bin positioned behind a door and a housekeeper was observed sweeping the floor around the residents. This detracted from a positive lunchtime experience for people who use the service.

We saw in one person's care plan that on 16 March 2016 their weight was 75.4kgs. On the 31 July 2016 this was 68.8kgs. Each time they had been weighed during that period of time they has lost weight. We explained this situation to the clinical lead at our feedback at the end of the second day of the inspection. They said they would investigate and take the necessary action to provide support and care to the person.

At 11.25 am on day one of our inspection, we looked at the 'Fluid Intake and Output Chart.' These had been written with a running total, the totals recorded for 4 August 2016 the total was 450mls (upon adding the fluids given together, we found it amounted to 550mls). On the 5 August 2016 the total was 635mls

The amount of fluid you need depends on many things including the weather, how much physical activity you do and your age, but European recommendations suggest 1.6L of fluid per day for women (about 8 200ml glasses) and 2L of fluid per day for men (about 10 200ml glasses). Reference, British Nutritional Foundation, Healthy hydration guide revised January 2016. Therefore we concluded people were not being given sufficient fluids which would make them unwell.

We saw a recorded dated on 9 August 2016, the intake total was recorded as 1100mls, but the actual amount was 950mls. We asked the clinical lead to ensure that staff took time to accurate record and added up the amount of fluid that people consumed in a day. In order that staff would be sure that people had received sufficient fluids and when not further fluids could be offered.

At 10.55am on the first day of our inspection, the person had a milk shake drink in a beaker on their bed table, we left their room at 12.10pm and the milk shake was still present.

We returned to the person's room at 14.15pm, the fluid intake and output chart now had intake entries recorded of: 10am – Tea, 11am – Tea, 12 noon asleep, 1.15pm cream shot 50ml, squash 150ml, m/s 200ml.

There is no evidence that the person has been referred or seen by a Speech and Language Therapist (SALT) to advise the pureed diet, there is no evidence that the person may require or was being given thickened fluids. The use of cream shots or milk shakes was not consistent and there is no evidence of an enriched diet or regular snacks being given to aid wound healing or weight gain.

We therefore could not be assured that the person's nutritional intake was being provided for or accurately recorded and they had not been referred to the SALT team for their support and advice.

We understood the new chef planned to have regular meetings with the manager to discuss ideas and resolve problems, However we were aware from talking with care and catering staff that they were aware of peoples dietary needs with regard to support with diabetes and allergies. However we did not see that a robust recording decision or communication was in place to ensure that all staff were aware of peoples.

This is a breach of regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nutritional and hydration needs of service users must be met.

The service worked with other professionals to provide support to people in their care. We were aware that the District Nurse team and quality team had provided support and advice to the service as requested.

A relative told us, "When [my relative] endured a chest infection, staff informed me that they would call a doctor to visit. They know I they didn't like making a fuss, but they did call the GP." In this case we could conclude the service had worked with other professionals to maintain people's good health.

Requires Improvement

Is the service caring?

Our findings

Two relatives told us they thought the care of the relative was extremely good and they could not find fault. We spoke with the person themselves and they could not recall how long they had been at the service or how they came to be there, but they liked the staff, especially the clinical lead. They were able to point to the person and told us, "They are very kind."

A member of staff told, "Caring is instinctive and that it came from the heart." They told us how much they enjoyed nursing and looking after people. Another member of staff explained to us they would describe "Good care as proper care."

We observed a member of staff supporting a person which included assisting them to the toilet discreetly and privately, thus respecting their dignity.

Positive interaction was observed between the housekeeper and two people who chose to spend time walking around the building. One person responded to encouragement and accompanied the housekeeper to a quiet area. They also persuaded a second person who was walking in stocking feet to wear shoes.

People told us that they did feel listened to and one person recalled there had been meetings to talk with the senior staff. They also informed us that they spoke with the clinical lead most days.

People and their representatives were invited to monthly residents meetings. A person stated that their [relative] accompanied them to a recent residents meeting as they were keen to meet the new manager and hear what was going on. They were encouraged to express their views and to make suggestions relating to areas of concern.

A relative told us, "The staff are excellent. When [my relative] arrived they were confused and hitting out at people for no reason. Staff were very kind and spent time talking to them. The doctor came and told us to wait for 24 hours before giving medication. They calmed down by themselves and did not need any medication."

Another person informed us that staff assisted them with personal care needs. They believed that after a period of two years at the service, their condition had improved, and they required less assistance. They told us, "But staff always ask me what I would like and before they leave they ask if there is anything else they can do."

One person told us how they had personalised their room with ornaments and family photographs. There was no facility to lock the room, however as they said they had no valuables, they did not think this was necessary. The clinical lead confirmed that people were encouraged to personalise the rooms, but during a tour of the service, doors were observed to be left open, and individuals were free to enter another resident's room. We have asked the service to consider this situation.

Locks were observed on external doors and windows downstairs. This included the doors to the enclosed garden, which restricted some individuals from freely entering the garden. We asked the clinical lead if the door to the enclosed garden could be unlocked and it was. The clinical lead was surprised this had not been done previously that day and said they would ensure the door was opened as a matter of course early each day.

Although we saw staff being polite and courteous to people during the inspection. Because of the failing we have identified that people were not being kept safe and as a result risks to their well-being increased. We did not consider that the service was caring to all people all of the time to meet their basic needs and have therefore rated the caring part of our the inspection as requires improvement

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of June 2015, we found that the provider had failed to establish an accessible system to receive, record, handle and respond to complaints made by people using the service. The provider sent an action plan to us explaining the improvements they were putting in place, which had been implemented by the previous manager.

We found improvements at this inspection. People using the service and their relatives said that they felt able to raise concerns and were confident these would be dealt with. One person said that they had raised some concerns and that the manager was dealing with them so did not wish to discuss the matters with us.

We examined the log of complaints and could see that issues raised had been taken seriously and had been investigated and responded to. We found that since March 2016 six complaints had been received. Each had been recorded and where it had involved a person at the service, they had been consulted and informed of the outcome. We found that where appropriate an apology had been issued and actions had been taken to prevent a reoccurrence of a similar incident. An example being was that staff were all sent the same message in the form of a memo and key staff were spoken with directly as well as care plans being reviewed.

Part of the action plan was to display the procedure for everyone coming to the service could see. This was in the main corridor along with information on duty of candour. Another element was to offer the opportunity to receive feedback from people. In the main entrance we saw visitor survey forms for anyone to take and a place to leave them.

One person informed us that they felt comfortable about raising concerns. They had cause to speak to the manager recently, and the manager "Had sorted it." They told us that they now had another issue stating that items of clothing had not been returned by the laundry, and intended to speak to the manager on their return from annual leave. But they were confident this would be resolved.

Three people told us that they were disappointed that the activities person was on two weeks leave and had not been fully replaced for that period of time. Other staff were trying to stand-in to support, alongside their usual duties. They said they would like to be engaged with more activities and on occasion to go out on trips as a group but that this was not available to them. We were aware that other staff, including the receptionist, were trying to stand in and arrange activities for people.

One person who had recently arrived at the service had an assessment before they moved into the service. This had highlighted some key aspects of their care that needed to be assessed upon arrival. However, we could not find any evidence that staff had actioned this and concluded that this had not happened as yet. The clinical manager gave an assurance that this person would be weighed and that a body map relating to any poor skin integrity would be completed immediately.

This would then enable staff to develop appropriate care plans to meet this person's needs. One person

who was receiving palliative care and was likely to be in pain had an Abby pain risk assessment in their care plan. This is for staff to use where people are unable to clearly articulate their needs. However, this was blank and had not been used. The person was on pain relief medicines but had other medicine prescribed for break through pain, we were not confident that nursing staff were consistently meeting this person's needs in this aspect.

We examined people's care plans and associated records. We found that in each case the service had completed their own assessment of the person's needs and had met them before they moved into the service. In addition and where appropriate the service had obtained information from other professionals involved in supporting the person. In one case this had been extensive and included information from health and social care professionals and included the person's GP and a previous care home where they had been specifically assessed.

We found evidence to support that people had been involved in the development of their plan. We saw that one person had the capacity to do so and had signed their plan to say they had understood the plan and were in agreement with it. A relative said that they liked, that part of the person's plans was kept in their private rooms. They said this was because their relative lived with dementia and they were unable to tell them about their day, But they could read the daily notes to see which staff had supported them and what they had done together. This enabled them to have conversations with their relative and support with care as they liked to do. Another relative said that they were very much involved and felt listened to.

It is important that care plans are kept up to date and accurate in order that the staff know the persons needs at that time and how to support the person. It is good practice to have a regular review with all parties present and also to review after significant events in the person life.

We found inconsistencies within the care plans with regards to regular review. Some were reviewed upon a monthly basis, but others did not keep pace with changed needs. Examples being a person who now required support to eat and was no longer independent and a person who their medicines dispensed by nurses and not as their plan had suggested. We looked at daily notes to corroborate and found that these were not always clear as they were not consistently legible. Therefore the practice may have been appropriate but the records did not always support this.

If the plans are not up to date people had the potential to receive inappropriate care from staff who may not know them well.
People did not consistently have opportunities to lead a lifestyle that suited them. On the second day of our visit we asked people how they would spend their day. A group of people told us there was nothing to do as the activities person was on leave. The receptionist was covering, but had two roles that day and was rather busy with answering the phone and the door. The one planned activity was a visit from a therapy dog. Several people enjoyed meeting the dog and petting him. We saw two people asking to go out. In the afternoon, on our suggestion, the door to a safe garden was opened for people to sit outside.

Inadequate

Is the service well-led?

Our findings

We were concerned about the management oversight of the service. The provider, manager and clinical lead had been unaware of the concerns identified during our inspection until these were outlined during feedback at the end of the inspection.

For example we saw in one person care plan, which was divided into sections, a yellow sheet titled 'Monthly Evaluation Checks' this lists the sections of the care plan, i.e. nutrition, moving and handling. There are no signatures for Month 1, Month 2 was dated 26 September 2015, Month 3 has no signatures. There was another sheet with Month 1 signed and dated 19 February 2016, there are no other records. Hence the care plan was not being reviewed appropriately to determine the care which was being provided.

We found some care records were incomplete and thus did not provide all necessary information about people's care and treatment. Daily care notes did not demonstrate the care people received each day. We also found that the provider was failing to assess, monitor and improve the quality and safety of the service. We raised this situation with the clinical lead at our verbal feedback at the end of the second day of the inspection and they were going to address the accurate recording of the daily notes.

It was not possible from the information recorded on the care plans to fully understand the current situation in relation to the care the people needed. We were concerned with the accuracy of recording and the care provided in regarding to one person's pressure areas for example.

For audits to be effective these need to be carried out regularly in sufficient quantity and action plan to resolve any issues identified. Although audits were planned monthly we found that less than 10 per cent in this example were audited, not completed and the action plans were not followed through
We reviewed the medication audits for the service and found that audits did not identify the errors that we had found on this inspection. The medication audit file of 8 June 2016 stated there were 37 people using the service but only 3 were audited. The audit identified for each audit there were ten items to check but only 3 of the ten were audited.

The audits that we did see of medicines were ineffective at identifying any errors on the MAR charts and when concerns were identified through the auditing process, there were no action plans or identified follow up actions carried out. This meant that there was a continued risk to people using the service as audits were not identifying all errors and those errors that were found were not being addressed.

The culture within the service did not promote effective communication or information sharing. Concerns identified about people's health and welfare was not shared effectively amongst the senior staff team. For example, the manager had not passed on information effectively about one person's care that had been admitted to the service regarding their capacity or this had been misunderstood which was the result of inaccurate record keeping. Colleagues discussing recorded information with regard to a person being admitted to the service would ensure the written information is fully understood and accurate would have resulted in staff working together collaboratively.

We found inconsistencies within care plans with regards to regular review. Some were reviewed on a monthly basis, but others did not keep pace with changed needs. Examples being a person who now required support with their eating and was no longer independent and a person who had their medicines dispensed by nurses and not as their plan suggested. We looked at daily notes to corroborate and found that these were not always clear as they were not consistently legible. Therefore the practice may have been appropriate but the records did not always support this. People could potentially receive inappropriate care from staff who may not know them well.

Good care is based upon an assessment of need and a clear care plan written in response to the persons assessed need of how the needs will be meet. A further example is that there was no evidence of a continence assessment having been completed for a person. However, the carers daily records indicate that the person was both urinary and had faecal incontinent.

Failure to effectively assess, monitor and improve the quality and safety of the service or to maintain an accurate, complete and contemporaneous record in respect of each person is a management failing.

This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems or processes must be established and operated effectively to ensure compliance with the requirements of this part of the Act.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that people's capacity to give consent was properly assessed, nor were MCA assessments kept under review.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that the care and treatment people received was provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The providers failed to address the needs of the people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to take steps to ensure they met people's nutritional and fluid needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

Diagnostic and screening procedures Treatment of disease, disorder or injury	The providers did not ensure that the premises were maintained to be safe and secure.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to effectively assess, monitor and improve the quality and safety of the service or to maintain an accurate, complete and contemporaneous record in respect of each person who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Person employed for the purposes of carrying on a regulated activity must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.