Lakeglide Limited

Ersham House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Ersham House Nursing Home on the 29 and 31 August 2017 and the inspection was unannounced. Ersham House Nursing Home provides accommodation and personal care, including nursing care, for up to 40 people. People had needs such as poor mobility, diabetes, as well as those living with various stages of dementia. The service also had a contract with the local authority to provide care and support for up to seven people to prevent unnecessary hospital admissions. There were 26 people living at the service on the days of our inspection.

An acting manager was in post but they were not yet registered with the commission. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager left the service at the end of October 2016. A previous acting manager had been in post from October 2016 to April 2017. The current acting manager took over in May 2017 and had been in post four months at the time of the inspection and told us they would submit an application to become the registered manager.

At the last inspection undertaken on 28 and 29 February 2017, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to; Regulation 9, people were at risk of social isolation. Regulation 11, people's care plans did not reflect their basic rights to consent and decision making. Regulation 12, evidence was not available to show that care was provided in a safe way and Regulation 17; effective systems were not in place to monitor the quality and safety of the service.

We asked the provider to take action to meet regulations 9 and 12. We took enforcement action against the provider and told them to meet Regulation 11 by 14 June 2017 and Regulation 17 by 14 July 2017. The provider sent us a report of the actions they were taking to comply with Regulations 9 and 12 and they told us they would be meeting these Regulations by 31 July 2017.

At this inspection we found the provider had made some improvements to the service and standards of care. Another activity coordinator had been recruited and staff no longer referred to people in an inappropriate manner. Prescribed fluid thickener was not left in easy reach of people. Staffing levels had increased and a dependency tool was now in place to assess what staffing levels were needed to meet people's needs. However, many improvements had not been made and we found continuing breaches of regulations from the last inspection. We also found new breaches of regulation.

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. 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.

Prior to our inspection, we received information of concern from an anonymous source that the consistency of people's pureed food was not in line with their assessed need as determined by Speech and Language Therapists (SALT). This is to ensure people who have swallowing difficulties do not choke. During the inspection, we observed a staff member pushing aside lumps within people's pureed food and a member of the kitchen team advised that the blender provided was not fit for purpose.

People did not consistently receive safe care and treatment. The management of catheter care was ineffective and placed people at risk. There was a lack of guidance for registered nursing staff to follow. Nursing staff did not consistently have oversight of people's air mattresses settings and a number of air mattresses were set at the incorrect setting which placed people at risk of their skin breaking down. Nursing staff regularly checked people's blood sugars, but diabetic care plans and risk assessments were not in place to ensure consistent safe care.

The principles of the Mental Capacity Act (MCA) 2005 were still not consistently applied in practice. Where people had bed rails, the provider could not evidence whether they had consented to the use of bed rails or whether they were implemented in people's best interests when people did not have capacity to consent. Relatives were signing consent forms without the appropriate authority to do so. People raised concerns about the restrictions imposed on their freedom. One person told us, "I certainly feel restricted from how I was living before. I've been here about five months. I'd like to go out in a taxi on my own and go shopping, then get a taxi back. I can't see why I can't; I did do it before I came here without any problems."

The management of medicines was not always safe as people did not always receive their medicines on time. Protocols for the use of 'as required' PRN medicines were not in place and pain assessment tools had not been implemented. Medicines were not always administered in line with best practice guidelines or the prescriber's instructions.

People's healthcare needs were met but communication with relatives was not consistently responsive. Healthcare advice had not consistently been followed by care staff. Staffing levels had increased since the last inspection in February 2017 but the deployment of staff was ineffective. People were left without staff supervision and engagement from staff. Restrictions on staffing levels meant people could not freely sit outside or access the garden. People remained at risk of social isolation. The provision of activities was not consistently meaningful and accessible to people with varying needs and preferences.

Safeguarding policies and procedures were in place but systems to ensure people were protected from harm or abuse were not consistently robust.

The provider continued to fail to maintain accurate, complete and contemporaneous records. People's daily monitoring charts were incomplete and included unexplained gaps and omissions. Staff had not all received up to date training or training to meet people's individual needs.

Whilst the quality assurance process identified and addressed some shortfalls, it remained ineffective. The provider lacked strategic oversight of the service. The management team were dedicated to making the necessary improvements, but these were not yet embedded or sustained. Shortfalls identified at the last inspection in February 2017 had not been addressed and the provider had failed to act on recommendations made at the last inspection. The lunchtime experience was not consistently positive for some people; this was because some people were having their meals sitting in the armchairs that they had spent most of the day sitting in. This didn't help people to orientate or know that it was time for their meal, nor did it aid their digestion or independent eating. We have identified this as an area of practice that needs improvement.

Staff spoke highly of the people they supported. People's right to privacy was respected and people spoke highly of the staff. One person told us, "The staff are very caring, they cuddle me and talk to me and cheer me up because I get very tearful, because of my legs." Advanced care plans were in place for people to discuss their wishes surrounding end of life care. However, these were not consistently completed. We have identified this as an area of practice that needs improvement.

People spoke highly of the food provided and for those who enjoyed group activities, a range of activities were on offer. These included arts and craft, card games and puzzles. Staff recruitment practice was safe.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Ersham House Nursing Home was not safe.

Peoples' safety was at risk. Medicines were not managed appropriately and people were not adequately protected from abuse or harm.

Staff were not appropriately deployed to meet peoples' individual needs. Risks to peoples' health and welfare were not always assessed or identified.

Staff recruitment practice was safe.

Is the service effective?

Requires Improvement

Ersham House Nursing Home was not consistently effective.

People were asked their consent for day-to-day decisions; however, the principles of the Mental Capacity Act (MCA) were not consistently applied in practice.

Most people were supported to eat and drink sufficient quantities to maintain their health, however it was not always clear what action had been taken when people had lost weight. People had a varied lunchtime experience.

Catheter care was not effective and staff did not always respond in a timely manner when people were unwell.

Is the service caring?

Requires Improvement

Ersham House Nursing Home was not consistently caring.

Most people received care that was kind and caring. However, not everyone was treated with dignity. Advanced care plans were not consistently in place.

People's information was treated confidentially. Personal records were stored securely. Staff had built positive rapports with people. The companionship that pets bring to older people was recognised by the management team.

Is the service responsive?

Requires Improvement

Ersham House was not consistently responsive.

People did not always receive person-centred care that met their individual needs. There was a lack of stimulation and interaction with people and people were at risk of social isolation.

People had access to a complaints policy, complaints were investigated according to the providers' policy. People's needs had been assessed and care plans were in place.

Is the service well-led?

Inadequate

Ersham House Nursing Home was not well-led.

The provider's quality assurance framework remained ineffective and placed people at risk of harm. Accurate, complete and contemporaneous records had not been maintained.

The culture of the service was task centred and the provider lacked strategic oversight of the running of the service.

Ersham House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 29 and 31 August 2017 and was unannounced. The inspection was prompted in part by a complaint from a whistle-blower. The inspection team consisted of four inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar services.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the service.

During the inspection we spoke with 12 people and two visiting relatives. We spoke with various staff which included the deputy manager, two activities coordinators, the chef, a kitchen assistant, four registered nurses and six care staff. On both days of the inspection, the acting manager was away but we spoke with them via telephone after the inspection. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated risk assessments for 12 people, as well as four staff files, medication administration record (MAR) sheets, records of incidents and accidents, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' people living at the home. This

is when we followed the care and support a person received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Ersham House Nursing Home on the 27 and 28 February 2017 where it was rated 'Requires Improvement.'

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Ersham House Nursing Home. One person told us, "This is my fourth year here and I really do feel safe." Another person told us, "I feel very safe here." A visiting relative told us, "I visit (person) twice a week, I've been doing this for the past 18 months they have been here. I think they are very safe." However people unanimously commented that the service required more staff.

At our last inspection in February 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the management of diabetes and percutaneous endoscopic gastrostomy (PEG) tubes was not consistently safe. Prescribed fluid thickener had also been left in easy reach of people. Areas of improvement were also identified in relation to medicines homely remedy procedures, deployment of staff and fire safety procedures at night. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by July 2017. At this inspection, we found improvements had been made in relation to fire safety procedures at night and some improvements had been made to the management of diabetes. However, the deployment of staff remained an on-going concern and further concerns around people's safety were found.

The deployment of staff was not consistently safe and placed people at potential risk of harm. At the last inspection in February 2017 we asked the provider to seek guidance on the safe deployment of staff. This was because call bells were constantly ringing and people told us they often had to wait to receive assistance from staff. At this inspection, although the provider had taken steps to drive improvement, staff were not sufficiently deployed to meet people's care needs. People were often sitting on their own or without activity or conversation. For example, on the second day of the inspection, four people living with dementia were left alone and unsupervised in the lounge area for up to and over 45 minutes. On the first day of the inspection, some of the time up to six people were sitting in the lounge and other times up to eight people were. People had call bells to hand but we observed that some people were unable to use their call bell. One person was observed to have dropped yoghurt on their trousers and was sitting on their glasses; we observed that they were left in this position for over thirty minutes before we sought staff's attention for them. The provider had implemented a dependency tool and based on this tool had increased staffing levels to seven care staff in the morning and six care staff in the afternoon. Two registered nurses were on duty throughout the day. The acting manager advised that staffing levels had increased by up to 84 hours in recent weeks based on the outcome of the dependency tool. The dependency tool considered the support people required around their personal care, eating, moving, risk, continence and interventions. However, the dependency tool failed to consider the level of support people required to meet their social, emotional and psychological needs.

The skill mix of staff deployed was not always safe as staff were not always suitably qualified, competent and skilled to provide safe care and treatment. This impacted on the quality of care that people received. For example, a number of registered nurses had not received up to date clinical training in skin care, catheter care and fluid and hydration. During the inspection, we identified a number of concerns around the management of skin integrity and catheter care which we have reported under the 'Safe' and Effective' domain of this report.

Staff, people and relatives told us that despite an increase in staffing levels, staffing levels remained insufficient and the deployment of staff did not consistently meet people's care needs. One staff member told us, "They have recently increased staffing levels to seven staff in the morning and six in the afternoon which has helped but ideally we need eight in the morning." People continued to tell us that they still had to wait for assistance when they pressed their call bell. One person told us, "There's not enough staff because I can't go out when I'd like to go. I can only go out when it suits them, not me. Some of the good staff have gone because they were unhappy. Because of people like (person – other person living in the service) we get by without enough staff. They keep an eye out and will get a nurse if needed. If I want a bath or a shower I have to pre-order otherwise it's a strip wash at the basin. I've pressed my bell and waited 44 minutes on one occasion a couple of months ago. There's no point in complaining. Staff will be with you one minute and then get called away, mostly they'll come back but sometimes they forget. When the bells are ringing and they often do, they go on, and on, and on and this makes me feel so angry."

There had been changes in the staff team and a number of permanent staff had left over previous months. The acting manager had ensured that agency staff were used to enable staffing levels to be consistent. However, there was a regular use of agency registered nurses and care staff, and as a result there was at times a lack of consistency, responsibility and accountability. For example, on the 24 August 2017, a night agency nurse was requested to change a person's leg dressing which they failed to do. This resulted in a safeguarding concern being raised with the local authority. Although people told us they recognised why the service was using agency staff, people expressed dissatisfaction. One person told us, "There is not enough staff all the time. Some evenings I feel I don't get anyone come in at all. There are all nationalities. I don't get the same person. Some can't speak the lingo, it's not their fault. To me it seems every day there is a change of agency staff and I haven't been able to build up a rapport."

The deployment and skill mix of staff was not sufficient and did not allow for people to receive safe, personalised and individualised care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines was not consistently safe. Guidance produced by the 'National Institute for Health and Care Excellence' advises of the importance of the six rights of administering medicines, which included right time. On the second day of the inspection, we observed that medicines were administered later than prescribed. For example, the registered nurse took three hours administering morning medicines to people, which meant some people were receiving their medicines which the prescribed instructions stated should have been administered at 08.00am. Some people required their medicines to be administered later as per the prescribing instructions. However, where people required their medicine to be administered around 08.00am, the registered nurse failed to record the times they were administered to ensure that there was sufficient time in-between dosages. The registered nurse told us, "I know the time that I administered analgesia (pain relief) to people, but I didn't record it." Care and support was provided to a number of people living with dementia who were not able to consistently relay their needs to people. Guidance produced by the Social Care Institute for Excellence advises that 'pain is a significant and under-reported problem in the older people with dementia, who may face an impaired ability to communicate that pain. Their pain can have functional implications, such as decreased mobility, mood and sleep disturbances, impaired appetite and exacerbation of cognitive functioning.' However, pain assessments or pain care plans were not in place to monitor the effectiveness of analgesia or whether the person could communicate if they were in pain. The acting manager told us they had identified this shortfall and were in the process of implementing a pain tool. However, in the interim, there was a lack of guidance for nursing staff to follow. Where people were prescribed analgesia and other medicines such as antipsychotic medicines on 'as required' basis, protocols were not in place to ensure their consistent use in line with the prescribers instructions.

'As required' medicines should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when 'as required' medicines should be administered and the steps to take before administering it. Medicine administration records (MAR charts) reflected that people prescribed antipsychotic medicines were not being administered the medicines on a regular basis. However, as the provider was using agency nursing staff on a regular basis, the lack of clear protocols posed the risk that agency staff would be unaware of the steps to take before administering 'as required' medicines. Where 'as required' analgesia was administered, nursing staff failed to record the time it was administered. For example, one person was prescribed oramorph (brand of morphine). The MAR chart reflected it could be administered twice a day, however when it had been administered, nursing staff hadn't recorded the time it was administered so that if the person required the medicine to be administered later, nursing staff would be unaware of the time they could next administer the medicine. Documentation confirmed that it had not been administered more than once a day. However, when it had been administered, nursing staff failed to record the time.

Guidance produced by the Nursing and Midwifery Council (NMC) provides guidance for standard management of medicines. During the inspection, we observed best practice guidelines being followed when nursing staff administered medicines. For example, they checked with the person they were happy to take their medicines, what drink they wanted and explained the purpose of their medicines. However, we also observed interactions where best practice guidelines had not been adhered to. For example, on the first day of the inspection, the registered nurse administered medicines to a person whilst they were eating their supper. The person was experiencing difficulty with eating and required one to one support with this. They became quite distressed and started to call out. We also observed the medicines trolley being left unlocked in a hallway whilst the registered nurse went into a person's bedroom to administer medicines. On the second day of the inspection, we observed a registered nurse checking a person's blood sugars at the dining room table in front of four other people. This raised concerns for the person's dignity, although the person provided consent they were not offered the opportunity if they wished for their blood sugars to be checked in private.

Risks associated with pressure damage was unsafe and placed people at risk of further skin breakdown. Management of pressure damage is an integral element of providing safe care to people living in nursing homes. A number of people received care and support on an air mattress (inflatable mattress which could protect people from the risk of pressure damage) and it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. A member of the management team told us that the settings of air mattress were recorded on people's MAR charts and nursing staff checked the air mattresses twice a day to ensure they were on the correct setting. On the inspection, we found that nursing staff had no oversight of air mattresses and had failed to identify when air mattresses were on the wrong setting. We found six air mattresses which were on the wrong setting which placed people at risk of skin breakdown. For example, one person's mattress was set to 25kg when it should have been 60kg according to their weight as noted in their care plan. Another person's air mattress was set to 90kg when it should have been 48kg according to their weight. We brought these concerns to the attention of a member of the management team to take urgent action and review all air mattresses. Subsequent to the inspection, we were informed that all air mattresses had been reviewed and people were now on the correct setting.

Where people had open wounds, wound assessments were in place which identified that the dressing had been changed in line with the assessed frequency. However, skin integrity care plans had not consistently been implemented when a person had developed a wound. For example, the daily notes for one person on 23 July 2017 identified that they had developed two small broken areas on their sacrum and a dressing was applied. A further entry in their daily notes on 26 July 2017 referenced that the sacrum continued to look

very red and another entry on 28 July 2017 found that their air mattress had deflated and was lumpy. A further entry on 23 August 2017 reflected that their air mattress was flat. On the first day of the inspection, we checked the person's air mattress with their permission and found it was flat. The registered nurse informed us that the air mattress had not been checked for three days. A skin integrity care plan had not been implemented despite this person being at high risk of skin breakdown and sustaining skin breakdown. Another person was living with reduced mobility and sustained a skin tear to their shin. However, a skin integrity care plan had not been implemented to identify how the risks associated with skin breakdown could be mitigated and managed. Failure to have oversight of air mattresses and doing everything that was reasonably practicable to manage the risk of skin breakdown placed people at risk of harm.

Failure to provide safe care and treatment, assess the risks to the health and safety of people and lack unsafe medicines management is a breach of regulation 12 of Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff had an understanding of safeguarding adults and could identify different types of abuse and knew what to do if they witnessed any incidents. Training documentation confirmed staff had received training in adult safeguarding and staff told us they would have no hesitation in raising concerns over a person's safety. However, despite staff's reassurance, we identified a potential incident where harm had potentially occurred to one person. For example, one person had raised concerns over an agency night care worker supporting them to move and transfer but in the process hurt their wrist. A member of the management team told us that the person had only just reported their concerns, despite the incident occurring three weeks previously. However, documentation in the person's daily notes reflected that the individual had raise concerns over their wrist hurting on a number of occasions in the past couple of weeks and informed a staff member on the 20 August 2017 of their concerns that an agency staff member had hurt their wrist. There was no incident report and no consideration as to whether a safeguarding concern was required to be made when the person raised concerns over the involvement of the night agency worker. Subsequent to the inspection, we were informed that a safeguarding concern had been raised and the staff members agency had also been informed.

People were not always protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in February 2017, the management of diabetes and percutaneous endoscopic gastrostomy (PEG) tubes was not consistently safe. This was because PEGs were not consistently advanced and rotated as advised in people's care plans. The management of diabetes was unsafe as there was a lack of guidance for nursing staff to follow. At this inspection, we were informed that no one was living with a PEG tube. We were therefore unable to review whether the care of a PEG tube was safe. We were therefore requested to see the provider's medicines policy to see if the policy had been updated since the last inspection to reflect the importance of PEG care. We found the policy had not been reviewed or updated. We have discussed this and the associated risks in the 'Well-Led' section of this report.

People living with diabetes can have an increased risk of disability, pressure ulcer development and hospital re-admission. At the last inspection in February 2017, the management of diabetes was not safe. Robust risk assessments were not in place and it was not clear what action was taken when someone experienced high blood sugars. At this inspection, we found that old diabetic risk assessments and care plans had been removed but new ones had not yet been implemented. A member of the management team told us, "We have been gathering information from people's GPs before we implement diabetic care plans. We have also been sourcing guidance for the registered nurses and have made folders for them with the guidance, so that when they implement the care plans, they have access to a range of information and guidance on what a

diabetic care plan should consist of." Despite, diabetic care plans not being in place, the management of diabetes was safe. People's blood sugars was checked weekly or daily and when people experienced high or low blood sugars, documentation confirmed appropriate action was taken. The absence of diabetic care plans had a low impact on people however we have discussed this and the associated risks in the 'Well-Led' section of this report.

Risks associated with fire safety at night had been addressed. At the last inspection in February 2017, we asked the provider to review their fire evacuation procedures at night. Improvements had been made. People's individual ability to evacuate the service in the event of a fire had been assessed and personal evacuation plans were in place. In the event of a fire at night, the provider operated a 'stay put' policy and this was reflected in people's individual fire evacuation chairs. Weekly fire alarms took place alongside fire drills and checking of emergency lighting.

People were cared for by staff the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the nature, skills and abilities of the permanent staff employed at Ersham House Nursing Home. One person told us, "I've no complaints at all, the staff are fine." However, people felt agency staff were not equipped to provide effective care. One person told us, "The agency staff are terrible."

At our last inspection in February 2017, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider was not working within the principles of the Mental Capacity Act 2005 (MCA). Areas of improvement were also identified in relation to the management of hydration and the environment not being a dementia friendly environment. We took enforcement action against the provider and told them to meet Regulation 11 by 14 June 2017. At this inspection, we found some improvements had been made, but these improvements were not embedded into practice and the provider continued to not consistently work within the principles of the Act.

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Training records documented that all nursing staff had received training on the Act and we saw examples of where nursing staff had worked in line with the principles of the Act. For example, one person was declining to sit on a pressure cushion. The registered nurse explained they had cause for concern that the person might lack capacity and therefore they completed a mental capacity assessment with the person where they identified that the person could retain, understand, weigh up and communicate their decision as to why they didn't want to sit on a pressure cushion. The registered nurse explained they were making an 'unwise decision' but that they had to respect that decision. Although we observed elements of practice where staff worked in line with the principles of the Act, we found this was not consistent.

At the last inspection in February 2017, we found decision specific mental capacity assessments were not in place for decisions such as the use of bed rails. At this inspection, decision specific mental capacity assessments were still not consistently in place. For example, where people had bed rails, bed rails risk assessments were in place, yet these failed to identify if the person consented to the use of bed rails or not. One person had bed rails in place and was subject to thirty minute checks. A bed rail risk assessment was in place and the registered nurse confirmed they had not completed a mental capacity assessment but felt the person likely lacked capacity. A consent form was in place for the use of bed rails which had been signed by the person's relative, however, staff had not identified whether the relative had appropriate authority (such as lasting power of attorney for health and welfare) to sign the consent form. A mental capacity assessment was available within their care plan but failed to document what specific decision was being made and at what time. Throughout their care plan there was reference to specific care plans being written with the person's relative as part of their best interest. It was clear staff were involving the relative and consulting them. However, there were no underpinning mental capacity assessments to demonstrate what decisions the person lacked capacity for. Another's person's relatives had signed their consent form which included

consent to photographs being taken and consent to bed rails. However, their pre-admission care plan identified that their relatives only had lasting power of attorney for finance and not for health and welfare. Therefore they did not have the appropriate authority to be signing the consent forms. We found this was a consistent theme within the care plans we reviewed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The provider had recognised when people were deprived of their liberty, however, the care planning process failed to identify how peoples care and support could be delivered in a least restrictive manner. For example, some people required the support of a fallout chair (chair which prevents people falling out). The use of a fallout chair could be seen as restraint as the person is unable to get out of the chair independently. Assessments for the use of fallout chairs were not in place and the rationale for the use of fallout chairs was not evidenced within the care planning process.

When receiving care in bed, some people required bed rails and were subject to thirty minute or hourly observations. Personal safety care plans were in place which explored how people could be kept safe. For example, one person's personal safety care plan identified that due to their advanced dementia; they were unable to use the call bell and required checking on hourly. However, the care planning process failed to explore whether these restrictions on people's care, were the least restrictive. There was no consideration about accessing community facilities and what support would be required for people to access the local community. People raised concerns about the restrictions imposed on them. One person told us, "I certainly feel restricted from how I was living before. I've been here about five months. I'd like to go out in a taxi on my own and go shopping, then get a taxi back. I can't see why I can't; I did do it before I came here without any problems." We raised these concerns with a member of the management team who identified that people's personal safety care plans should identify how they can be supported to access the community and agreed this was an area to focus on.

The provider and acting manager had started to take steps to ensure they worked in line with the principles of the Act. Consent care plans were in place and guidance had been provided to all nursing staff on the MCA 2005. Staff members were observed offering people choices, such as what to eat, what to drink and staff understood the importance of consent. However, these changes were not yet embedded or sustained and capacity assessments were not consistently in place for specific decisions. Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating. The layout of the dining room had been changed since the last Inspection in February 2017. The dining room was now within the communal lounge. The tables were neatly decorated with flower arrangements, condiments and napkins and people were offered two meal options with any alternatives. On the first day of the inspection, we observed four people having their lunchtime meal at the dining room table whilst seven people were having their meals sitting in the armchairs that they had spent most of the day sitting in. This didn't help people to orientate or know that it was time for their meal, nor did it aid their digestion or independent eating. Staff confirmed some people preferred to have their lunchtime meal sitting in their chair, whereas some staff members raised concerns that some people

remained in their chair and not were taken to the dining room table as it was easier for staff. For people sitting at the dining room table, they were able to engage and talk with one another; however, for people who remained in their chairs, the environment was not conducive to a social meal time experience as people were not able to communicate with one another as they were sitting in separate arm chairs. We brought these concerns to the attention of the management team to address and have identified this as an area of practice that needs improvement.

Before the inspection, we received information of concern that the consistency of pureed food was not based on people's needs and was placing people at risk of choking. Guidance produced by the Social Care Institute for Excellence advises that 'a dysphagia diet features different textures of foods and liquids that can make it easier and safer for people to swallow. These textures make it easier to chew and move food in the mouth and reduce the risk of food or liquid going into the windpipe or trachea, which leads to the lungs.' A number of people had been assessed by speech and language therapists (SALT) and required a stage 'B' thin puree diet. A stage 'B' pureed diet requires that the person should not have to the chew the food and it is smooth without any lumps. On the first day of the inspection, we observed a staff member comment, 'Oh dear, there's lumps in this mash, I'd better be careful.' We then observed them pushing the lumps to one side. Staff members raised concerns that this had been an ongoing concern. A member of the kitchen team demonstrated that the blender they had been provided with was not fit for purpose to blend the food to the required consistency. They advised, "We raised our concerns about the old blender and were provided with this blender until we received a new one. However, we have struggled getting the consistency right with this blender." On the second day of the inspection, a new blender was in situ. We checked the consistency of the pureed meals and found the food was to a consistency which met people's individual care needs. Incidents reflected that no harm had occurred to people whilst the kitchen staff were awaiting a new blender. Staff confirmed they had been checking the consistency of the pureed food when supporting people to eat and drink, which minimised the risk of harm. Failure to monitor and take prompt action is noted in the 'Well-Led' section of the report.

Care and support was provided to a number of people living with swallowing difficulties. Some people had been seen by speech and language (SALT) to manage the associated risks and guidelines were in place for staff to follow. However, we found staff were not consistently following these guidelines. One person required their fluids to be given in an open glass (no lids) with no straws as assessed by SALT. However, on the second day of the inspection, we observed this person sitting in the lounge with their glass with a straw. We brought these concerns to the attention of a staff member who removed the glass and updated the person's guidelines in their bedroom. Staff were responsive to our concerns and took action immediately. However, staff were dependent upon inspectors to identify this shortfall. We have identified this as an area of practice that needs improvement.

People were regularly assessed for nutritional and dehydration risk. Where people were at risk of malnutrition, the provider utilised the malnutrition universal screening tool (MUST) and staff regularly monitored people's weight on either a weekly or monthly basis. Where people were at risk of losing weight, actions were implemented to increase calorie intake. This included the use of smoothies and fortified diets. Input had been sourced from the dieticians and speech and language therapists (SALT). People remained satisfied with the food provided and we observed staff supporting people with eating and drinking at lunchtime in a kind and sensitive manner. One person told us, "The food is good enough. I've no complaints. If they offered me something I didn't like they will change it."

Risks associated with catheter care were not adequately addressed and placed people at risk of harm. Where people had catheter's in-situ, robust catheter care plans and risk assessments were not in place. For example, staff told us that one person's catheter was known to by-pass regularly. Documentation reflected

that in August 2017, there had been two incidences of the catheter by-passing and the person was admitted to hospital on one occasion due to urinary retention. The person told us, "I have lots of problems with my catheter; it bypasses a lot and causes me a lot of pain." However, despite complications with the catheter, their elimination care plan included the note 'care plan needs re-writing.' This note was documented on the care plan on the 3 August 2017. The original care plan failed to include any guidance on the size of the catheter, how often it should be changed or what to do in the event of the catheter bypassing. The provider had recognised that the care plan required reviewing, however the care plan still had not been updated or reviewed since the 3 August 2017. This posed a risk that staff did not have sufficient guidance in place to follow to ensure that robust and effective catheter care was provided. Staff were required to document and monitor the person's fluid intake and output. Monitoring of people's fluid intake and output with a catheter is called fluid balance monitoring'. These measurements help to enable nursing staff to evaluate for any signs of infection or imbalances. However, staff were not consistently recording the individual's output. Documentation often just recorded 'draining.' A member of the management team confirmed that they would expect staff to record the output. An incident form dated 2 August 2017 noted that that person's catheter was blocked and following review of their daily notes, there had been no documentation the previous night of staff checking the catheter and no output had been recorded. Failure to record the output meant nursing staff had no oversight of the amount of fluid intake compared with output to enable effective monitoring for any infections or signs of by-passing.

Information on when people's catheter's had to be changed was hard to locate within people's care plans. This posed a risk for agency nursing staff that they would be unable to locate this information easily. For example, one person had their catheter changed during a hospital admission, yet the date for the next catheter change was not documented and the information on the catheter change in hospital was not easily accessible. Another person's catheter care plan was dated December 2015. Nursing staff informed us that this person now attended hospital for re-catheterisation; however, this was not reflected in their care plan and posed a risk that agency staff would be unaware of this. Training records were not clear on when nursing staff last had catheterisation training and one registered nurse advised that their training on male and intermittent catheterisation was now out of date. This posed a risk that nursing staff were not clinically trained to provide effective catheter care. People's catheter care plans also failed to identify what catheter care was required, when the catheter bags should be changed or any information on the size of the catheter and the date for when it was due to be changed. Failure to assess and mitigate the risk of harm around catheter care placed people at risk of harm. We brought these concerns to the attention of the acting manager to take immediate action.

The provider had failed to ensure that people received safe support with their healthcare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Peoples' health needs were assessed upon admission to the service and people had access to external healthcare professionals when required. Records showed that people had access to GPs, opticians, speech and language therapists (SALT) and TVNs. People told us they felt their healthcare needs were met and they had access to healthcare professionals. One person told us, "The doctor calls in, he is so nice, has a lovely bedside manner."

Guidance produced by Skills for Care advises on the importance of a 'strong skilled workforce.' As part of staff's induction at Ersham House Nursing Home, staff shadowed other senior members of staff and completed mandatory training which included safeguarding, moving and handling and fire safety. If staff members were new to care, they completed the Care Certificate. The Care Certificate sets the standard for new health care support workers. The acting manager recognised the importance of staff development and training and informed us that a number of staff were being supported to obtain national vocational

qualifications (NVQS) in health and social care. They also identified that there had been a focus on ensuring all staff were up to date with mandatory training before providing training that was specific to the needs of people they supported. However, we identified that MCA and DoLS was not considered as mandatory training. Although staff understood the principles of consent and this was observed during the inspection, failure to deliver training meant staff were unaware of the statutory principles or what might constitute a deprivation of liberty safeguard. The training matrix reflected that registered nurses had recently completed training but not all care staff. The training matrix also identified that not all registered nurses had completed recent training in fluid and nutrition and only two registered nurses out of seven had completed training in skin care. The acting manager confirmed that they were focusing on the training programme and considering what training was required to ensure staff had the necessary skills and abilities to provide effective care. We have discussed the associated risks of this within the 'Safe' and 'Well-led' section of this report.

Requires Improvement

Is the service caring?

Our findings

We saw that most staff were kind, caring and positive. Warm relationships had developed between some people and staff. With pride staff spoke about the people they supported. One staff member told us, "We support one gentleman who is ever so funny. He loves beer and football and also loves banter." People told us that staff were kind and supportive. One person told us, "The staff are very caring, they cuddle me and talk to me and cheer me up because I get very tearful, because of my legs."

Observations showed that some staff explained their actions, gained peoples' consent and supported people according to their needs and preferences. On the first day of the inspection, the hair dresser was visiting the service. Throughout the day, staff commented on people's hair. We heard comments such as, 'your hair is lovely' and 'you look beautiful today.' Staff were seen holding people's hands and recognised the importance of human touch. However, our observations showed that not all people were treated in a respectful or dignified manner.

On the first day of the inspection, we arrived at the service at 08.50am and met one person sitting in the lounge. They were sitting clutching an object of importance which staff told us they held at all times. Throughout the inspection, we checked on this person and found throughout the inspection, they remained in the same chair clutching this item of importance. At the end of the inspection at 18.10pm, this person was in the same chair and we could not be assured that they had been supported to change position, sit in a different chair, meet their continence needs or freshen up. At the end of the inspection, their top was stained and they had spilt yoghurt on their trousers but they had not been supported to change their trousers. Daily notes reflected they had only drunk 50mls throughout the day and documentation also reflected that they hadn't had a bowel movement in 16 days. We brought these concerns to the attention of a member of the management team to address and review the person's provision of care and we requested that they feedback to us on the second day of the inspection. On the second day of the inspection, we were informed that this was a recording issue as the person had experienced a recent bowel movement. Although staff had reassured the management team this person had been supported to reposition and meet their continence needs, they were unable to advise at what time and who supported the person to change position and meet their continence needs. We escalated these concerns to the acting manager. Subsequent to the inspection, the acting manager confirmed they had been monitoring the person's daily notes to ensure the provision of care was meeting the person's care needs. Failure to provide person centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Nursing homes play an important role in the care of older people at the end of life. Guidance produced by the Department of Health advises that for many, 'a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. Some people had advanced care plans in place. Advanced care plans considered, 'what was important to the person, what people they wanted involved in their care and the place they wanted to pass away.' Not everyone had a completed advanced care plan. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time. We have identified this as an area of practice

that needs improvement.

People were supported to maintain their diversity, sexuality or religion. Care plans included guidance on people's religion and if they continued to practice their faith. With support from relatives, people were able to attend local churches and where required Vicars and Priests visited the service. Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. One staff member told us, "I was helping one person to choose what to wear and I showed them a pair of trousers and I got a firm no. Giving people those options and choices is really important."

Guidance produced by Age UK advises on the importance pets bring to older people and the management team continued to recognise this. One person told us, "Dogs and pets come in, my nephew brings in a dog and he's made to feel welcome. Last week they had a chicken come in from some farm, it was very friendly and sitting on laps." They also added, "I had the chicken sitting on my lap and it was wonderful to stroke it."

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

People were encouraged to maintain relationships with their family and friends. People were able to have visitors to the service and observations showed that they were welcomed. During the inspection, relatives were seen visiting their loved ones and some relatives also brought along their dogs which people enjoyed interacting with.

Staff understood the importance of respecting people's privacy. One staff member told us, "When supporting people with personal care, I always ensure the door is closed, curtains are drawn and they are supported to cover their top half whilst their bottom half is washed." People also confirmed that their privacy and dignity was respected. One person told us, "They always tap on the door before they come in. When I get post they don't hang around and wait to see what it is, they leave me to open it on my own."

Requires Improvement

Is the service responsive?

Our findings

People's needs were first assessed when they moved into the service. Care plans were developed and people felt staff worked very hard. One person told us, "The staff work very hard, long hours, it's a 12 hour day but they are very caring." However, people's experience of responsive and person-centred care varied. Not everyone received care that enhanced their quality of life.

At our last inspection in February 2017, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there was a failure to mitigate the risk of social isolation. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by July 2017. At this inspection, we found steps had been taken to drive improvement but these improvements were not embedded into practice and the risk of social isolation had not fully been addressed.

Guidance produced by the Social Care Institute for Excellence (SCIE) recommends 'that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation'. Observations of some staff practice showed that at times staff took the time to speak to people and interact with them. However, observations demonstrated that staff missed opportunities to engage with people. For example, on the first day of the inspection, a staff member was observed supporting people to drink, yet failed to engage with people when supporting them. Other observations demonstrated that staff engaged with people in a kind manner, enquiring about their day and how they were. However, this was not consistent.

The provider employed two dedicated activity coordinators, however, on the first day of the inspection, neither activity coordinator was working and no staff member was allocated to undertake activities. Staff told us that due to the pressures of meeting people's personal care needs they did not have time for activities or to support people on a one to one basis for those who preferred to stay in their bedroom. During the inspection, we observed that a number of people remained in the lounge with only the TV for stimulation. Guidance produced by the Social Care Institute for Excellence advises that older people have choice and control within their life. During the inspection, we found that the television remained on the same channel and people were not offered a choice of what they wished to watch. One person who spent all day in the lounge regularly called out to staff as they walked past, asking 'what can I do now?' Staff replied advising that supper would be along soon and then they could go to bed. One staff member informed us that this person loved to sit outside, however, due to staffing levels on the days when activity coordinators were not working, they were unable to sit outside with people. On the first day of the inspection, it was a sunny warm day, yet nobody was offered the choice to sit outside or go for a walk in the garden. Another staff member told us, "It's a beautiful day today, yet no one is sitting outside as we don't have enough staff so that one staff member can sit out here with people."

Staff members raised concerns that people were isolated and not supported to go outside or access the local community. One staff member told us, "There was a trip out recently but only four people went. Otherwise, I can't recall the last trip out. Although there are BBQs, people don't sit outside. They cook the

food outside then bring it in. When the activity coordinators are not here, there is not enough staff to enable people to sit outside as they need supervision. I am worried that people are lonely." Another staff member told us, "Oh yes, I think people are lonely and isolated." Observations on the second day of the inspection, identified that even with two activity coordinators in, people were still left unoccupied in the lounge. For example, six people were in the activity room participating in cards and puzzles, while four people living with dementia were sitting in the lounge, with no staff supervision and only the TV for stimulation. We queried why these people were not supported to engage in meaningful activities. The activity coordinator told us that they were also supporting people in the activity room to try the newly fitted oven in the activity room. This meant that the two activity coordinators were engaging with a group of six people in the activity room whilst four people living with dementia were in the lounge with the TV for stimulation and engagement. One person told us that they were not particularly interested with watching the television. We observed that these four people remained in the lounge during the duration of the morning activity. We brought these concerns to the attention of the management team to address.

Staff members told us that they didn't have time for activities or to sit with people as they were engaged in personal care tasks. One staff member told us, "We have residents with very high care needs which makes it difficult and takes a lot of our time. Although the manager tries to get regular agency staff, when we have new agency staff it takes longer as we are supervising them and explaining what to do. We don't have time to take people outside or provide activities when the activity coordinator is not here." Another staff member told us, "We just about meet people's personal care needs and that is about it."

The deployment of staff was insufficient in meeting people's social, emotional and psychological care needs. This is a breach of Regulation 18 of the Health and Social Act 2008 (Regulated Activities) 2014.

On the first day of the inspection, there was a lack of stimulation and interaction for people. During the inspection, we asked to see the activity book which detailed information on the activities that people had participated in. We were informed that the book was locked away in the activity cupboard and no staff members had keys. The cupboard was eventually opened and within the cupboard was the activity book and access to a range of activities such as puzzles, arts and crafts and other activities. However, the action of the activity cupboard being locked reflected a culture whereby the provision of activities was separate to the care provided by staff members. We discussed with the a member of the management team why the cupboard was locked in the absence of the activity coordinator as this meant staff had no access to activities. They advised that they thought it may have been a health and safety reason but that they were unaware that no one else had a key. They agreed to take action and ensure that staff had access to activities at all times.

On the second day of the inspection, both activity coordinators were available and we observed a range of group activities which included puzzles and cards. The activity timetable demonstrated the following activities were on offer; games club, film club, armchair movement and afternoon tea. The activity coordinator told us, "Each week I gain feedback from everybody on what activities they would like to do the following week." However, the activity programme also reflected a lot of free time. For example, during the week commencing 28 August 2017, people had free time on the 29 August 2017 all day and in the afternoon at weekends. Although activities were provided, staff raised concerns that it was always the same people who attended the activities and activities were not tailored for people living with dementia or whose who preferred to stay in their bedroom. Documentation reflected within the activity book identified that it was the same people participating in the group activities. For those people, they were receiving activities that were meaningful. One person told us, "We are always doing things." However, for some people, the provision of activities were not meaningful, did not enhance their quality of life and the risk of social isolation had not been mitigated. One person told us, "They do bring in someone to sing or play an instrument. It can be quite

boring here though. They give us 'free time', as if we haven't got enough of it! I'm lucky because I've chummed up with a couple of the other residents and we chat and play cards but if I was relying on entertainment I'd be very disappointed." Another person told us, "A lady from a farm brings in baby animals each month, everyone loves to see them. There's not that much going on here. If it wasn't that I've got [name] and [name] to talk to I'd be quite bored. Otherwise it's the telly."

Steps had not been taken to address the risk of social isolation. At the last inspection in February 2017, we found people could go up to 11 days without a meaningful one to one from the activity coordinator. Improvements had been made and people saw the activity coordinator on a more regular basis, however, documentation failed to reflect how one to one visits were based on people's hobbies, interests and were meaningful to them. The provider's action plan advised that they would provide training to staff on dementia, person centred care and therapeutic activities. A member of the management team confirmed they were still sourcing this training. The action plan also stated that, 'This is me' booklets would be completed. 'This is me' booklets were designed by the Alzheimer's society and provide a useful forum for people to capture their life history, hobbies, interests what's important to them. The acting manager told us that some booklets had been handed out but they had not yet been returned. People had social care plans in place but these did not consistently reflect people's hobbies, interests and what activities were meaningful to them. For example, one person's social care plan identified that staff should offer the person the opportunity to come to the lounge for activities or to make sure they were offered one to one if they preferred to stay in their bedroom. There was no information on their life history, interests or hobbies to help aid staff or the activity coordinators on how to provide meaningful activities for this person.

People did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Guidance produced by Social Care Institute for Excellence advises on the importance of communication within care homes. Staff spoke highly of communication within the service and most relatives felt the management team communicated effectively with them and they were informed of any changes in their loved one's care needs. However, we observed one interaction whereby communication was not responsive. During the inspection, one relative approached us and commented, "I'm not happy. There aren't enough staff and they're not helping enough. My loved one saw the doctor last Thursday. The doctor prescribed special antiseptic ointment and it's now Wednesday, six days later, and they still haven't got the ointment. This is totally out of order, what's going on, why isn't anyone chasing for it. I think they are waiting to get it from the chemist they deal with but I want to know can they not get it from somewhere else? Also, I asked the nurse three quarters of an hour ago to take my loved one's temperature. They are not right. I know they are not right because normally they like their tea, they can drink gallons of the stuff. They are turning away and talking gibberish. That's not right. I've asked for them to be put to bed. We've been together 63 years and I know whether my loved one is right or not. They haven't been yet and taken their temperature." We requested that the registered nurse to take the person's temperature which confirmed they had a high temperature. The person's loved one queried with the registered nurse what they were going to do, in which they replied, 'maybe call the doctor.' We raised these concerns with the acting manager and requested confirmation that action had been taken. Subsequent to the inspection, we were informed that a decision had been made by a healthcare professional not to prescribe the ointment cream and antibiotics were prescribed. However, this had not been communicated to their relative to help them understand why the cream had not arrived. We have identified communication with relatives as an area of practice that needs improvement.

People's needs had been assessed before they moved into the service to check whether the service could accommodate these needs. A care plan was then devised based on the pre-admission assessment. These

assessments provided an account of the person's needs in relation to their medicines, communication, nutrition, continence, skin integrity and mobility. Care plans considered the assessed need and risk and the support required along with the desired outcome. For example, care plans considered people's preferences around getting up, going to bed and night time care. One person's care plan noted that they preferred to have a duvet rather than a sheet and there was preference was to get up early in the morning. One person told us, "They don't ever force you to get up, I get up when I want and I get my breakfast brought to me."

There was a complaints policy in place. Complaints that had been made had been dealt with appropriately and according to the providers' policy. People told us that they felt comfortable raising any concerns. One person told us, "If I was unhappy, I say something." Since the last inspection in February 2017, documentation reflected that the provider had received two complaints. However, it was unclear what changes had been made and lessons learned in response to the complaints that had been made. We have identified this as an area of practice that needs improvement.

Inadequate

Is the service well-led?

Our findings

People and their relatives spoke highly of the new manager. One person told us, "The manager is doing a good enough job." A visiting relative told us, "The new manager is very nice. They are amiable and listened to what I had to say. They have given me confidence that there will be more regular staff and things will improve." Another relative told us, "I like this home, I'm very, very pleased we got my Mother in here." Whilst all feedback of the management was positive, we found areas of practice which were not well-led.

At our last inspection in February 2017, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because accurate and complete records had not been maintained, the service had a task centred culture and the provider's quality assurance framework was not robust. We took enforcement action against the provider and told that they must address the concerns 14 July 2017. At this inspection, we found some improvements had been made, but these improvements were not embedded into practice and continued concerns were identified.

People were not protected by the provider's systems and processes to monitor the quality of the service. As a consequence of this, the provider had failed to recognise that some aspects of the service had been deteriorating since our last inspection in February 2017. For example, they had failed to identify nursing staff were not always providing safe care and treatment, people's care records were not accurate, people were not protected from risks associated with their care, medicines were not managed safely and principles of the mental capacity act were not being adhered to.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager left the service at the end of October 2016. A previous acting manager had been in post from October 2016 to April 2017. The current acting manager took over in May 2017 and had been in post four months at the time of the inspection and told us they would submit an application to become the registered manager. Therefore the service had been without a registered manager for over ten months and had experienced a turnover of one registered manager and one acting manager in the space of a year.

Accurate and complete records were still not being maintained and documentation was unclear and contradictory at times. At the last inspection in February 2017 we found a range of discrepancies with people's topical medicines records and bowel movement charts. At this inspection, we continued to find a range of discrepancies. For example, one person was prescribed a barrier cream to be applied daily. Documentation reflected it had only been administered 11 times since 25 January 2017. Another person living with skin breakdown was prescribed a barrier cream, however, the topical medicines application record failed to record how often the cream should be applied. Documentation reflected that it had only been administered on 14 occasions since 28 January 2017.We found this was a consistent theme across the topical medicines application records we reviewed. Bowel movement charts continued to contain omissions and unexplained gaps. For example, one person's bowel movement chart reflected they had not

experienced a bowel movement in 5 days when usually they experienced a bowel movement every other day. Another person's bowel movement chart reflected they had not had a bowel movement between the 13 August and 21 August 2017. We brought these continued concerns to the attention of a member of the management team who told us, "This is an on-going issue and we have sent letters to the nurses and in the last couple of days we have recently introduced the 'RN 24 hour handover check sheet.' This is a checklist that the registered nurses have to complete at the end of every shift and that checks whether care documentation such as bowel movement charts and topical medicine record charts have been completed correctly. This should ensure that the nurses have oversight of any omissions or gaps in recording." The management were taking steps to address these concerns. However, gaps and omissions with documentation had been an ongoing concern since February 2017.

Some documentation was contradictory and unclear at times which posed a risk that staff did not have sufficient guidance to follow to provide safe care. For example, the weekly weights for one person documented that they had lost four kilograms between the 12 August 2017 and 26 August 2017. Their nutritional care plan dated 25 July 2017 made no reference to weight loss and it was not clear what action had been taken. We brought these concerns to the attention of the acting manager who provided different weight recordings on different dates from the ones we viewed on the inspection which reflected the person had put on weight. Therefore it was unclear as to what weight recordings were accurate and whether the person was losing or gaining weight. This increased the risk of care not being safely monitored.

The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided. At the last inspection in February 2017, the provider was in breach of Regulation 9, 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Recommendations for improvement were also made and the provider submitted an action plan detailing how improvements would be made by 31 July 2017. The provider had not met their action plan. We found continued concerns and where a number of concerns and issues had not been fully addressed. For example, at the last inspection in February 2017, the management of diabetes was not safe. Diabetic risk assessments were not robust and failed to provide staff with sufficient guidance to follow. At this inspection we found that nursing staff were checking people's blood sugars and taking action if there blood sugar was found to be too high or too low. However, previous diabetic care plans and risk assessments had been removed from people's care plans and new care plans and risk assessments were not yet in place. A member of the management team told us, "We have been seeking information from people's GPs on their diabetes before compiling diabetic care plans." A letter was sent to all registered nurses on 15 August 2017 about diabetic care plans and what to include within the care plan and risk assessment. However, on the days of the inspection, diabetic care plans were not in place, despite this being a breach of regulation at the last inspection.

At the last inspection in February 2017, the management of percutaneous endoscopic gastrostomy (PEG) tube was not consistently safe. This was because PEG tubes were not consistently being advanced and rotated as advised in people's care plans. At this inspection, no one was living with a PEG tube; therefore we were unable to review the management and safety of them. We were informed by a member of the management team that guidance on the care of the PEG tube would be reflected in policies and procedures surrounding medicines. We reviewed policies and procedures pertinent to medicines and found the provider had failed to review and update their policies and procedures in light of the concerns raised. Policies and procedures failed to provide guidance on the importance of advancing and rotating PEGS and where nursing staff should record the advancement and rotation of PEGs. This posed the risk that for any future people living at Ersham House Nursing Home with a PEG tube, nursing staff would be following policies and procedures which had not been reviewed and updated to reflect best practice guidelines around the advancement and rotation of PEGs. Subsequent to the inspection, we were informed that guidance around

PEG care was available within in a clinical handbook produced by an external source and pre-admission assessments would determine if the service was able to meet the care needs of a person with a PEG. Despite these measures in place, the provider's internal procedures and policies had been not reviewed following the findings from the last inspection in February 2017.

Care and support was provided to a number of people prescribed fluid thickener. Fluid thickener is used to help people who have difficulty swallowing. At the last inspection in February 2017, we observed on two occasions that the fluid thickener had been left available in communal areas for people to pick up. Prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. At this inspection, improvements had been made and fluid thickener was observed to never be left out in communal areas. A generic risk assessment was in place for the use of fluid thickener, however, this risk assessment was not personalised to those prescriber fluid thickener. Guidance produced by NHS England patient safety alert advises that, 'individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected.' Action had been taken to ensure prescribed fluid thickener had not been left within easy reach of people. However, action had not been taken to ensure individualised risk assessments were in place for people prescribed thickening powder.

Care and support was provided to a number of people living with dementia. Guidance produced by the Alzheimer's society advises that a safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. At the last inspection in February 2017, we found that the environment at Ersham House Nursing Home was not specifically designed for people living with dementia and signage was not readily available. A recommendation was made and subsequent to the inspection in February 2017, we were informed that signage had been ordered. At this inspection, we found that the signage was not on display and steps had not been taken to ensure the environment was dementia friendly. The acting manager told us, "I'm awaiting approval from the provider to implement the signage." Throughout the inspection, we observed that most people could independently navigate the home and find their way about.

Guidance produced by Social Care Institute for Excellence (SCIE) advises that 'accountability for the care and safety of people who use services, and staff ultimately lies with the provider and management team. Nonetheless, each worker has a responsibility to contribute to accountability within an organisation through an integrated approach. This means there has to be clear communication systems and clarity about roles and responsibilities, with well-defined lines of accountability.' On both days of the inspection, the provider and acting manager were away. A member of the management team had oversight of the service whilst they were away. However, during the inspection, we were unable to review a number of key pieces of documentation and paperwork as they could be not located or the member of the management team did not have access to them in the absence of the acting manager. For example, during the inspection, we were unable to review satisfaction survey results, audits and action plans, resident meeting minutes and policies and procedures. We were also unable to locate any incident or accident forms from May and June 2017. We raised concerns with the management team around accountability and business continuity. The management team agreed with our concerns. This demonstrated that the provider's system and processes to ensure the smooth running of the service in the absence of the acting manager was not robust.

There was lack of strategic oversight at provider level on the running of the service and the provider had failed to maintain an effective overview of the service. The provider continued to visit the service on a weekly basis and now held weekly meetings with the acting manager which considered staff training, staffing levels, maintenance and 'residents' needs. The manager also submitted a weekly report to the provider which included information on the number of complaints received that week, safeguarding concerns, number of wounds and number of incident and accidents reported that week. Subsequent to the inspection, we

queried what strategic oversight the provider had and whether the provider reviewed any action plans to ensure the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 were being met. The acting manager told us, "I bring along the audits and action plans for discussion." Despite the acting manager bringing along audits, the provider had a lack of oversight and had not identified a number of shortfalls with the provision of care and that the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 were not being met. Where concerns had been raised to the provider, the provider had not consistently acted upon these concerns. For example, the kitchen team had identified that the blender provided was not fit for purpose. In the interim, a new blender had been sought but again this blender was not fit for purpose. A member of the kitchen team told us, "We've been having to use this blender for a couple of weeks and we can't blend the food properly." Urgent action was not taken, despite the associated risks of lumps in pureed food.

Guidance produced by Skills for Care advises that for a service to have a person centred culture, staff need to understand that 'each person has their own identity, needs, wishes, choices, beliefs and values. One size fits all does not work when it comes to providing care and support.' At the last inspection in February 2017, we found that staff referred to people in an inappropriate way. When responding to call bells, staff called out the person's bedroom number, rather than their individual name. At this inspection, we found improvements had been made and staff no longer referred to people in an inappropriate manner. However, the ethos of the service remained task centred rather than person-centred. One staff member told us, "It's awful here. There is always agency staff. We don't have time for activities and because there's not enough staff, especially when the activity coordinators are not here. We don't have time to support people to sit outside or go out in the garden." Observations demonstrated that staff appeared focused on the task at hand or the next task. Some staff members were observed sitting with people and having a chat but other observations demonstrated that staff missed opportunities to engage with people. Where people tried to interact with staff, staff advised what was happening next such as 'it's nearly supper time', rather than enquiring what the person wished to do or what they would like to happen. One person requested to go to bed but was later told by a staff member they could return to bed after supper. This observation was indicative of a task centred culture rather than a person centred culture.

Systems to assess and monitor the service were not robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection. A number of shortfalls had not been addressed which placed people at risk of harm. During the inspection, we identified within a staff communication book concerns about people not being supported to meet their continence needs. The entry was dated 18 May 2017 and noted concerns that six people had not received support to meet their continence needs. One entry noted, 'person was soaking wet and had filthy t-shirt on. Their last pad change was 10.30am. And nothing's been documented till 19.00pm.' Another entry noted, 'Their last pad change was at 14.35pm and found they were drenched in urine and had dried faeces on them.' We were unable to locate any incident reports and enquiries into what happened on this day. We could not be assured that the provider had internally identified this issue and taken action. Incident and accident documentation from 15 May 2017 also reflected a further incident whereby staff raised concerns that a person was found in the morning with faecal marks on their sheet and dry faeces on their underwear. Although this was reported via an incident form, we could not see what strategic oversight the provider had of these concerns and what action was taken to drive improvement and ensure people's care needs were met.

People were at risk of their health care needs not being met and being placed at risk of harm. The provider's internal quality assurance framework had failed to identify that nursing staff's clinical training was not up to date and which meant nursing staff may not always have the skills, competency and ability to provide safe care and treatment. During the inspection, we identified concerns with the management of skin care and

catheter care. Competency assessments of nursing staff had not been completed, although the acting manager had devised a competency assessment which was to be rolled out for all nursing staff. However, in the interim, people were at risk of receiving care and staff that did not meet their needs or promote their well-being.

The failure to ensure effective systems were in place to regularly assess and monitor the quality of the service and to take action to make the required improvements is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team did show dedicated to the on-going improvements of Ersham House Nursing Home. A member of the management team told us, "We've had to start from scratch and implement new systems, structures and procedures which take time to embed and sustain. I've been working on compiling resources folders for all the registered nurses and care staff which contain guidance on diabetes, Mental Capacity Act 2005 and how to provide safe care and treatment. We've been trying to source training and have been devising competency assessments for registered nurses. We've been working really hard and making the desired changes that we want to make takes time." Throughout the inspection, the management team were open and responsive to our concerns and took action immediately to ensure the safety of people living at Ersham House Nursing Home. Subsequent to the inspection, the acting manager confirmed they would be making an application to the Dementia In-Reach Team to help with the provision of dementia care and meaningful activities for people living with dementia. The management team had clear visions and actions to implement. However, these improvements were not yet embedded into practice and a number of issues identified from the last inspection in February 2017 had not yet been addressed.

People and their relatives spoke highly of Ersham House Nursing Home. One person told us, "I came here from the hospital. I had to move to a nursing home. I'm quite happy with what I've got here." Visiting relatives told us they felt their loved ones were safe and that they felt confident in the skills and abilities of the acting manager to make the required improvements.