Mrs R Halsall

Malvern 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

Malvern Nursing Home provides accommodation and nursing care for a maximum of 28 adults with complex mental health needs. The service is located in a residential area of Bradford approximately two miles from the city centre.

We inspected Malvern Nursing Home on the 12 May 2016 and the 21 June 2016. Both visits was unannounced. There were 23 people using the service when we inspected.

Our last inspection took place in August 2015 and at that time we found the home was not meeting four of the regulations we looked at. These related to staffing, person centred care, dignity and respect and good governance. We required the provider to make improvements and following the inspection they sent us an action plan outlining the action they intended to take including timescales.

Following the last inspection we met with the registered provider/manager and they informed us that they were stepping down from the role of manager for health reasons and were looking to appoint a Registered Mental Nurse (RMN) to become the registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection the registered provider told us although they had advertised for several months for a Registered Mental Nurse (RMN) to take on the role of registered manager the position had still not been filled. They confirmed the clinical lead nurse continued to be the "acting manager" and would remain in that role until a new manager was appointed. However, the acting manager did not want to be considered for the post on a permanent basis.

Shortly after the inspection we received confirmation from the provider that they had decided to promote from within the existing senior staff team and the assistant manager had been offered and accepted the position of registered manager.

At this inspection we found staffing levels had been maintained and recruitment for additional support workers was ongoing. However, we found the staff recruitment and selection procedure was not always being followed which might allow people unsuitable to work in the caring profession to be employed. We saw a part time activities co-ordinator had also been appointed since the last inspection. The majority of people we spoke with told us this had had a positive impact on their daily life and enabled them to access more community based activities.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within

the legal framework of the Mental Capacity Act 2005 (MCA).

We saw the complaints policy had been made available to everyone who used the service. The policy detailed the arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

The care plans in place contained individual risk assessments which identified specific risks to people's health and general well-being, such as falls, mobility, nutrition and skin integrity. However, we found they did not always provide accurate and up to date information which might lead to people receiving inappropriate care and treatment. We also found that although medication policies and procedures were in place nursing staff did not always follow the correct procedures which potentially placed people at risk of not receiving their medication as prescribed.

We saw people were offered varied a range of homemade meals but concerns were raised about how staff monitored people's weight and ensured their nutritional intake was sufficient. We also saw examples of institutional care and routines which resulted in inadequate standards of care or poor practice which denied people choice or curtailed their independence. For example, although people were encouraged to make choices about what they ate and drank they were not allowed to carry out simple self-care tasks such as buttering their own toast, pouring their own drinks or putting sugar and milk in their drink. These tasks were carried out by the support workers. In addition, we saw the daily routines such as mealtimes and the times people were given drinks and cigarettes were very rigid and restrictive and did not promote independence.

We found improvements were still required to the quality assurance monitoring systems in place as they were not robust and had not identified the shortfalls in the service highlighted above and in the body of this report.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines management was not always safe and effective, which meant people did not always receive their medicines as prescribed.

Staff recruitment and selection procedures were not always robust which might lead to people not suitable to work in the caring profession being employed.

Risks to people's health, safety and welfare were not always properly assessed and mitigated.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff were supported to meet people's needs by means of a planned programme of staff training, supervision and appraisals.

The location was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were referred to relevant healthcare professionals if appropriate.

Although people were offered choice of meals we had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff interacted with people in caring manner and people

appeared at ease and relaxed in their company.

People's appearance suggested they were not being supported or encouraged to maintain the standard of cleanliness they should expect.

Care records lacked evidence to show people were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although care records completed for people's mental health provided detailed information, the care records relating to people's physical health were not always up to date and staff did not always follow the advice and guidance of other healthcare professionals .

The service had started to implement a planned programme of social and leisure activities both within the home and the local community.

A system was in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led

There was no registered manager in post.

There were quality assurance monitoring systems in place which were designed to identify any shortfalls in the service and non-compliance with current regulations.

However, the system were not robust or consistently applied therefore we could not be sure the service was managed effectively and in people's best interest.

Malvern 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 12 May 2016 and the 21 June 2016 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor in Mental Health.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We looked at people's care records, medicines administration records (MAR) and other records which related to the management of the service such as training records, staff recruitment records and policies and procedures.

We spoke with eight people living in the home. We also spoke with the registered provider, the acting manager (clinical lead nurse), the assistant manager, one qualified nurse, the administrator, four support workers, the cook and cleaning staff. We also spoke with one visiting healthcare professional.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home.

We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

Inadequate

Is the service safe?

Our findings

At a previous inspection in January 2015 we found a regulatory breach in relation to medicines as nursing staff did not always follow the correct procedures when administering medicines and medicines were not always administered as prescribed. When we inspected the service again in August 2015 we found although some improvements had been medication was still not always administered as recorded on the person's medicines administration record (MAR). However, on this occasion due to mitigating circumstances we found no breach in regulations.

At this inspection we found medicines were administered to people by trained nursing staff. We were told no people at the home had been found to have the capacity to self-medicate. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found medicine trolleys; cabinets and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator temperatures were checked and recorded to ensure medicines were being stored at the required temperatures.
Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. We saw changes to medicines in care plans and on medicine administration records (MAR) were signed by a nurse. We also saw evidence of correspondence as a result of Care Programme Approach (CPA) meetings which had altered people's medication. We saw these changes had been recorded in daily care records and transposed onto MAR sheets.

However, our observation of medicine administration showed some aspects were sub-optimal and potentially unsafe. For example we witnessed one person being administered their medicines without reference to the MAR sheet. The nurse told us they knew what medicines the person was prescribed. Whilst the medicine was administered accurately it was not administered in accordance with the Nursing and Midwifery Council Standards for medicine management which states "registrants must check that the prescription or the label on medicine dispensed is clearly written and unambiguous."

We saw the nurse prepare two people's medicines in the treatment room, put both un-labelled medicines in a receiver (kidney dish) and proceed to administer the medicines in a different location in the home. This practice increases risk of people been administered incorrect medicines. Furthermore guidance contained in the National Institute for Health and Care Excellence (NICE) guidance on the management of medicines in

care homes says, "Care home staff must record medicine administration, including the date and time, on the relevant medicines administration record, as soon as possible and ensure they complete the administration before moving onto the next person."

We saw one person was prescribed a thickening agent to be added to fluids to lessen the risks of choking. We saw the nurse add a scoop of Thick and Easy to a fluid being used to aid swallowing tablets. We saw the tin of Thick and Easy had no label indicating who the product was prescribed for. Furthermore the thickening agent administered was different to that named on the prescription. We asked the nurse where the prescribed product was stored. We found the tin to be unopened which indicated the correct thickening agent had not been administered for some time.

We saw all as necessary (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. We saw any known allergies and intolerances to medicines were recorded.

The medicine administration record (MAR) sheets had been in use for less than a week at the time of our inspection. We therefore looked at the previous four weeks of MAR sheet entries. We saw on one occasion the supply of medicines had become exhausted due to a change in the dosage of the medicine. We saw the person was prescribed an antipsychotic medicine twice a day but for three days the evening dose had been omitted because of insufficient stock.

We conducted an audit of nine medicines supplied in individual boxes. We found an antipsychotic medicine to be administered at night had not been added to the current MAR chart which commenced on 9 May 2016. However, the tablets in stock were accurately recorded on the rolling stock sheet completed by nurses after each administration. This showed us nurses were not checking the MAR sheet before administering medicines and were not signing the MAR sheet after administration as the MAR had no record of the prescribed antipsychotic medicine. We found on three occasions out of our random sample of nine boxed medicines we were unable to reconcile stock levels to the current MAR sheets as no carry forwards of stock had been recorded. Only retrospective audits of the previous MAR sheets allowed us to reconcile stock levels.

Our inspection of medicines showed the provider was not adhering to the National Institute for Health and Care Excellence (NICE) guidance on the management of medicines in care homes. We found medicines were unable to be reconciled on all occasions and where reconciliation was possible there were instances of unaccountable stock levels. We found medicines prescribed for one person were being administered to another person who was not prescribed the product. We found MAR sheets were not been updated at the end of each cycle with the result some medicines were being administered without reference to the current MAR sheet.

This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The care records we reviewed included risk assessments relating to individual risk in areas such as smoking, moving and handling, nutrition, falls and the prevention of pressure damage to the skin. Although some assessments were well completed we found there were discrepancies in others we reviewed. For example, we saw the malnutrition universal screening tool (MUST) for one person had not been completed since 2013, although their care plan showed they were nutritionally at risk and should be weighed weekly. The weight records in the person's care file showed they had last been weighed in April 2015 when they were 65kgs and every entry since then stated the person had refused to be weighed. Yet we saw a separate weight chart

which showed the person's weight to be 59kgs in February 2016. The MUST tool provides information about alternative measurements which can be used to assess a person's nutritional risk if they are not able to be weighed. There was no evidence to show these had been considered. As the MUST had not been completed the level of nutritional risk to this person as a result of this weight loss had not been determined. We asked the acting manager about this and they were unable to provide us with any further information about this matter. We saw one person had two different assessment tools to determine the risk of developing pressure ulcers. One was blank and the other had a score of 19 but there was no information with the risk assessment tool to explain what this score meant in terms of the level of risk.

In relation to the risk assessments completed for people who smoked we saw some historic care records which evidenced careless disposal of cigarettes had resulted in fires which had endangered other people. Therefore each person concerned had an individual assessment which addressed safety issues but which unreasonably restricted them from smoking. Assessments considered the servicer user's physical ability and mental capacity to undertake smoking activities safely. However the actions to mitigate risks were unreasonable and produced a rationing system where many people's days and emotions were regulated by the time the next cigarette could be had.

We looked round all areas of the home with the assistant manager. We found most areas of the home were clean and fresh, although odours were noted in four bedrooms, which the assistant manager told us would be addressed. We saw many of the rooms had divan beds and noted some had no headboards fitted. When we asked why it was not clear who had made the decision to remove these or why. All the single bedrooms had call bells with leads which were accessible to people from their beds. However, we observed in the five shared rooms there was only one call bell point. Three of these rooms were occupied by two people and we saw only one of the people in each of these rooms had access to a call bell from their bed. This meant the other person had no means of summoning help from staff when they were in bed.

We saw there were free standing radiators in two bedrooms. One of these radiators was on full and the surface temperature was very hot. We asked the assistant manager if risk assessments had been completed for the use of these appliances and they said no. Although they told us they would deal with this straightaway the provider had not identified this risk or put measures in place to protect people prior to our intervention.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at records of servicing and maintenance and saw regular checks and tests had been carried out as required and were up to date. This included gas safety, electrical wiring installation, fire safety equipment, hoist, chair lifts and legionella.
The acting manager showed a good understanding of the safeguarding procedure and since the last inspection had used the procedure correctly to notify both the Care Quality Commission (CQC) and the Local Authority of incidents at the home.

The support workers we spoke with understood what may constitute abuse and knew how to protect people from avoidable harm. They told us they had attended training and were able to explain their responsibilities with regard to keeping people safe. They were aware they could report suspected abuse externally to the Local Authority and CQC.

We looked at the minutes of the last two residents' meetings and found people who used the service had been reminded by staff about what constituted abuse and how to report suspected abuse. The acting

manager told us this was an agenda item at all residents' meetings.

At the last inspection we found the provider had reduced the staffing levels on the afternoon shift from five support workers to four. We found evidence to show this had been done for financial reasons and was impacting on people's ability to access events and facilities in the local community. Following the inspection we received confirmation from the provider that staffing levels had been increased and there were now always five support workers on day duty.

On this inspection we found the provider had maintained the increased staffing levels. The rota showed there was always at least one qualified nurse and five support workers on duty during the day and one qualified nurse and two support workers on night duty.

However, the support workers we spoke had differing views on staffing levels. For example, one support worker told us although there were five staff on day duty, one person received one to one support and at times other people needed staff to go with them to outpatient and GP appointments. This meant the home was left short staffed. However, other support workers felt the home was always adequately staffed and the recent appointment of an activities co-ordinator had enabled people to access more community based activities. This matter was discussed with the acting manager and assistant manager who told us if additional staff were required on specific shifts to meet people's needs the number of staff on duty was always increased.

We saw there was a recruitment and selection policy in place. The assistant manager responsible for staff recruitment told us as part of the process they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people.

We looked at three staff files and found a robust recruitment procedure had been followed for two of them. All three staff had completed application forms, gaps in employment were checked and interview notes were recorded. We saw checks had been completed which included two written references and a criminal record check through the Disclosure and Barring Service (DBS). However, the records for one person showed they had commenced in post before written references had been received. One reference was undated and the other was dated almost a month after the person had started. Neither reference had been verified. This was discussed with the assistant manager who confirmed in future no one would be employed until satisfactory references had been received.

Requires Improvement

Is the service effective?

Our findings

Our discussions with the cook showed people were offered a varied range of homemade meals which included a meat and vegetarian curry every day as well as other main course choices such as fish pie, chicken casserole and pasta. There were no menus displayed or available, although the cook told us these had been in place in the past. This meant people were not aware of the meals on offer until they were asked by the cook shortly before lunch what they would like from the available choice. It was evident the cook took pride in their work, knew people well and had a good understanding of their dietary preferences and needs.

We saw snacks such as homemade cakes and biscuits were offered with hot and cold drinks in the morning and afternoon. The cook told us staff had access to the kitchen at night so if people wanted any food or drink this was available.

However, we found the provision of meals and drinks followed a fixed routine which did not promote people's independence or take into account their individual preferences. For example, breakfast was served at 9am and everyone was brought into the dining room. We asked the cook if anyone had their breakfast at a different time and they said only if they had an early appointment. People were offered choices of drinks, cereals and toast but everything was prepared and served by the staff and nothing was on the tables. So if people were having cereal staff asked the person if they wanted milk and sugar and put it on. A large tray of buttered toast was brought round and handed out on plates, drinks were poured out and any milk and sugar added before being given to the person. We saw the same process happened throughout the day with everyone being brought into the dining room for mid- morning and mid-afternoon drinks as well as mealtimes.

The culture within the staff team meant they just followed the daily routines without ever questioning why they were in place, or if there was a better way of working which might respect people's individuality and give them back some dignity and respect.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient. For example, one person's weight records showed they had lost 8kgs between November 2015 and March 2016. There was no malnutrition universal screening tool (MUST) in place for this person, although a separate nutritional assessment had been completed which assessed them as 'cause for concern'. The nutritional care plan was dated 31 January 2016 and identified the person was nutritionally at risk, was to be weighed monthly and weight changes were to be reported to the nurse in charge. We saw monthly reviews since January 2016 made no reference to this person's continued weight loss.

We looked at another person's records and were unable to determine their height or weight as the information was contradictory. For example, the person's height was shown on one record as 6ft 1inch, on another 5ft 7inches and a third recorded 5ft 6inches. One weight chart showed the person was 72kgs in

February 2016, another 73kgs and a third recorded 76kgs. The nutritional care plan dated 15 March 2016 showed the person was at high risk of malnutrition and said to maintain current weight for the next six weeks, although it was not clear what this was, and to weigh weekly. The last weight recorded in the care records was on 1 March 2016.

The acting manager showed us a monthly weight chart which listed all the people in the home. The chart started in November 2015 and went up to October 2016. Entries were recorded for November 2015 and February and March 2016. Twenty four people were listed, six had no weights recorded and 10 other people had lost varying amounts of weight of between 1kg and 11kgs in the period from February to March 2016. When we asked the acting manager about these weight losses they said they thought the weighing scales were wrong and needed to be changed and would address this. However, we were concerned that these weight discrepancies, which indicated some people may have lost significant amounts of weight, had not been identified or addressed by the acting manager since they had been recorded in March 2016.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw seven people were subject to DoLS authorisations and of these four had conditions attached. We saw from care plans the conditions had been incorporated into the plan and were subject to regular review.
Community Treatment Order's (CTO) were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged into a community setting whilst still being subject to mandatory conditions. Any breach of these conditions can lead to recall into hospital and detention under Section 3 of the Mental Health Act 1983. We spoke with the acting manager about the CTO and conditions involved. They had a thorough understanding of the conditions and the part they played in supporting the person to maintain the conditions.

We saw one person had been identified by nursing staff to have deteriorating mental health. The nurse had informed the responsible clinician who had recalled the person to hospital for treatment and a period of observation. The person had successfully been returned to the home as a result of timely intervention by the nurse and appropriate therapy in hospital.

During the inspection we spoke with a visiting psychiatrist who told us they had confidence in the abilities of the trained nursing staff to accurately and professionally translate their wishes into appropriate care. They told us the nurses where aware of the conditions of the CTO's and were competent to act in accordance with their wishes to ensure timely interventions took place.

We saw in one person's DoLS best interest assessment was recorded the need for staff to use restraint should the person resist staff reapplying dressing to their legs. This was one of the reasons the managing authority had submitted the DoLS authorisation request. We saw the best interest assessors comments were incorporated into care planning which clearly recorded the need to use restraint if necessary. We spoke with

the acting manager about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. They also demonstrated their understanding restraint should only be used in a way which respected dignity and protected human rights. They had a good understanding of acceptable restraining techniques which were the minimum required to achieve the desired effect. We were told whilst restraint could be used, calming techniques and effective communication meant restraint was rarely used. The person's care plan confirmed this to be the case.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form.

The assistant manager confirmed that newly employed support workers completed an induction programme. This consisted of essential training and shadowing experienced support workers so new staff could get to know the people they would be supporting and working with. The assistant manager told us all new staff that had no previous experience in the caring profession also completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We spoke with two recently employed support workers one of whom had no previous experience in the caring profession. This staff member confirmed they had completed the Care Certificate and shadowed an experience support worker for five days as part of their induction training. They told us they felt well supported by the acting manager and senior staff team and were not afraid to ask for assistance if required. Both support workers confirmed they had had at least one supervision meeting with the acting manager since taking up post.

The training matrix we looked at showed in addition to mandatory training courses support workers had also recently completed training on mental health awareness, managing challenging behaviour and the MCA and DoLS. The support workers we spoke with told us they were happy with the training provided and felt they could approach the acting manager or assistant manager and request specific training if it was relevant to the needs of people in their care.

We saw individual staff training and personal development needs were identified during their formal one to one supervision meetings. The acting manager told us the goal was for every support worker to have a formal one to one supervision meeting with a designated senior staff member on a three monthly basis. However, they confirmed this timescale had fallen slightly behind.

The records we looked at showed arrangements were in place that helped to ensure people's health needs were met. We saw evidence staff had worked with various community based healthcare professionals and made sure people accessed other services in cases of emergency, or when their needs had changed. This included GPs, hospital consultants, community mental health nurses, social workers, chiropodists and dentists. We saw some people had been diagnosed with a chronic physical illness. In these cases we saw evidence of interaction with relevant health care professionals. For instance one person had insulin dependent diabetes mellitus. We saw this person attended diabetic retinopathy clinics. We saw two people were of an age and gender which had led to an invitation to attend the breast cancer screening service. We saw evidence in care plans where the reasoning for the invitation had been discussed with the individuals who had subsequently accessed the service. The letter informing the person of the outcome of the examination was held in the care file.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found people were not always being treated with dignity and respect as a result of institutional and poor care practices. On this inspection we saw evidence people were still not always being cared for with dignity and respect. We saw people's appearance suggested they were not being supported to maintain standards of cleanliness they should expect. We saw some people's clothing was ill-fitting, not well ironed and stained with food. One person walked about throughout our inspection either holding their trousers up or with their trousers exposing their underwear. At no time did we see staff assisting showing any concern for the person's well-being in a meaningful way.

We looked in a shared room which was occupied by two people and found a lack of personal toiletries. Although we saw shaving equipment and shampoo for both people, there was no soap and no oral hygiene products such as toothbrushes, toothpaste or denture cleaning solution. The assistant manager who was showed us around the home told us the people would use the dispensed soap for washing but could not explain why there were no oral hygiene products for people to use.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care planning was an inclusive element of the service with many people benefiting from a Care Programme Approach (CPA). The CPA is a way services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of complex needs. We saw the outcomes of CPA meeting were translated into written care plans. We saw three people had been appointed with independent mental capacity advocates (IMCA) at the time DoLS were authorised. We saw evidence IMCA's had been involved in care planning reviews.

Whilst care planning included direction on some elements of care they lacked evidence to show people were involved in their care planning. We saw no evidence in planning which would encourage staff to include 'talk-time' or give people the chance to voice concerns or simply have a chat. We took the opportunity to talk with one person who appeared withdrawn and to be experiencing auditory hallucinations. Within five minutes the person's mood changed and they started to lead the conversation. They started to smile and invited another person to join our conversation. We asked what it was like to live at the home, one person said, "It's boring", and the other person instantly said, "Yes it's boring." I asked what they would like to do, one person said nothing, the other said, "I'm just waiting for a cig."
We observed support workers were caring in their interactions with people and people appeared relaxed in their company. When we asked one person what the staff were like they said, "They're good." Another person said, "They help me if I need it. I like all the staff they take me out sometimes."

The support workers we spoke with told us that they respected people's privacy by ensuring they knocked on bedroom doors and spoke to people when entering. One support worker told us, "When I am helping a person with personal care, I always make sure the bathroom or bedroom door is closed and the person is happy for me to assist them."

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care records and found these provided detailed information about people's needs which included the support they required from staff and any preferences. The provider information return (PIR) completed by service showed care plans were audited on a three monthly basis. We found information about people's mental health needs was well recorded. For example, we spoke with a person who we had met on a previous inspection visit. We noted a decline in their mental health status. We spoke with the person who was experiencing auditory hallucinations and exhibited delusional thoughts. A conversation with the acting manager and a review of care plans showed our observations had been identified and an appropriate referral had been made to the person's psychiatrist.

However, we identified some shortfalls in the records relating to people's physical care needs and how this care was delivered. For example, one person's wound care plan showed the treatment regime which had been advised by the tissue viability nurse. When we met this person our observations indicated this regime was not being followed. We spoke with the support workers who told us the person related well to particular staff members and that wound dressings were usually changed following a weekly bath.

We looked at this person's daily records from 19 April 2016 to the date of the inspection and found no record to show the dressings had been changed during this time, although there were three entries stating the person had refused to have the dressings changed. Although the acting manager and one of the nurses told us the dressings had been changed they were unable to provide any evidence to confirm this.Another person's wound care plan required updating as it did not reflect the current dressing regime and referred to district nurses who the acting manager advised were no longer involved in the treatment.

In addition, our observations throughout the day of inspection showed the care and support provided by staff was not person centred and did not promote people's independence and choice.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us since the last inspection the service had appointed a part time activities co-ordinator who worked flexible hours including evenings and weekends. The people we spoke with told us the activities co-ordinator encouraged them to participate in a range of activities both within the home and the local community. For example, one person told us they had gone with the activities co-ordinator to purchase soil and plants for the hanging baskets and had enjoyed the outing. They took great pleasure in showing us the hanging baskets at the front of the home which they had helped to plant out. They said, "I really enjoyed helping it gave me something to do and we going to organise a trip to the either to a zoo or the sea side which should be a good day out."

Another person told us they had been shopping with activities co-ordinator and had enjoyed joining in the craft work sessions they organised. They said "It can be really boring living here but at least now we get to do things and go out more." The majority of people we spoke with told us the recent appointment of an

activities co-ordinator had had a positive impact on their daily lives although some people made it clear they had little or no interest in joining in activities and refused to participate.

On the day of inspection the activities co-ordinator was not on duty but we saw support workers played board games or did jigsaws with a small a group of people in the dining room although many people were not engaged in any meaningful activity. We also saw as at the last inspection examples of institutional care and routines which resulted in inadequate standards of care or poor practice which denied people choice or curtailed their independence as highlighted in the "Safe" and "Effective" sections of this report.

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The policy also detailed the timescales within which the complainant would be dealt with. The assistant manager told us that people were actively encouraged to air their views and opinions of the service so that areas for improvement could be identified. We looked at the complaints register and saw the complaints received since the last inspection had been dealt with appropriately and within the timescales set out in the policy document.

Inadequate

Is the service well-led?

Our findings

When we met the registered provider on 30 July 2015 and the 13 October 2015 they informed us that they were stepping down from the role of registered manager and were looking to appoint a Registered Mental Nurse (RMN) to become the registered manager. They confirmed they had advertised the position and provided evidence of this.

At this inspection the registered provider told us although they had advertised for several months for a Registered Mental Nurse (RMN) to take on the role of registered manager the position had still not been filled. They confirmed the clinical lead nurse continued to be the "acting manager" and would remain in that role until a new manager was appointed however the acting manager did not want to be considered for the post on a permanent basis.

The provider told us they continued to visit the home on a regular basis and held a weekly meeting with the acting manager and assistant manager to discuss operational issues. However, they confirmed they had no involvement in the day to day management of the service.

Following the inspection we received confirmation from the provider that they had decided to promote within the existing senior staff team and the assistant manager had been offered and accepted the position of registered manager.

At the last two inspections we found the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the governance of the service. We found staff at times lacked leadership and direction and there were no effective systems in place to monitor the service provided and drive improvement. We also found the senior management team lacked a shared vision of the aims and objectives of the service and there were no clear lines of communication or accountability.

At the last inspection we found some improvements had been made to the internal audit system and quality assurance monitoring systems in place. We also found the acting manager and assistant manager were working more closely together to ensure there were clear lines of communication and accountability within the senior management team.

However, although the acting manager had identified the reduction in staffing levels imposed by the registered provider had impacted on people's ability to access community based activities, no action had been taken to address this matter until it was highlighted through the inspection process.

At this inspection we found the internal audit and quality assurance systems were still not robust and had failed to identify the shortfalls in the service highlighted in the body of this report. For example; we found medication was not always administered as prescribed and the staff recruitment and selection procedure was not always being followed. In addition, we found risk assessments and records relating to people's physical care and treatment did not always provide accurate and up to date information which might have

resulted in them receiving inappropriate care and treatment. Had the quality assurance systems in place been robust these areas of concern would have been identified sooner and without us having to bring them to the attention of the registered provider and acting manager.

This demonstrated the registered provider still did not have suitable systems in place to assess and monitor the quality of the services provided or to identify, assess and manage risks to the safety and well-being of people who used the service.

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

We looked at how the registered provider gathered the views and opinions of people who used the service and their relatives and how they used the information to improve the quality of the service. We saw both resident and staff meetings took place, which gave people an opportunity to air their views and opinions of the care and facilities provided.

In addition, the assistant manager told us as part of the quality assurance monitoring process the service sent out annual survey questionnaires to people who used the service, their relatives and friends, staff and other healthcare professionals to seek their views and opinions of the care and support they received. The assistant manager confirmed the information provided was collated and an action plan formulated to address any concerns or suggestions made.

We looked at the responses from the most recent survey carried out for healthcare professionals in March/April 2016. We saw six questionnaires had been returned from a range of healthcare professionals including a consultant psychiatrist, a GP, social workers and community nurses. The questionnaires showed everyone was satisfied with the standard of care and treatment provided. Comments included "Good quality care and standards seen for our clients. Staff are very helpful and knowledgeable" and "I receive excellent feedback from the staff and in particular (name of acting manager) who has full details about patients and their care." However, although the feedback from healthcare professionals was positive it was not consistent with our findings.

We also looked at the survey results for people who used the service and their family and friends and again found the majority of comments were positive and people's care, treatment and support. However, four people who used the service indicated they were not involved enough in decisions about their care.

The assistant manager confirmed that information form the surveys had not yet been collated or an action plan formulated. We therefore asked the assistant manager to forward us this information once available.

We saw the provider had the current CQC rating for the service on display at the entrance to the home and in the dining area.