Rosecare Homes Limited

Andrin 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

This inspection took place on 23 April 2018 and was unannounced. We returned on 24 April announced and 2 May 2018 unannounced.

Andrin House Nursing Home did not have a 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.

The manager of Andrin House Nursing Home was on planned leave at the time our inspection. A manager of the registered person's other service based in Leicester, facilitated the inspection.

Andrin House Nursing Home accommodates up to 37 people in an adapted building. At the time of the inspection 24 people were using the service. People using the service have an identified nursing need, which includes people living with dementia.

Andrin House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The overall rating for the service awarded at the previous inspection which took place on 1 and 14 June 2017 was requires improvement at which time we identified two breaches of the regulations. Following the last inspection we asked the provider to take action to make improvements to promote people's safety and to improve systems and processes to monitor the quality of the service. The provider submitted an action plan outlining their plan for improvements.

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 expectations 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 being 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 month, 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 service 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 no longer rated as inadequate for any of the five key questions it will no longer be in specialist measures.

The registered person and manager did not have systems and processes to assure themselves as to the quality of the service being provided. This lack of oversight as to the quality of the service and the services governance meant shortfalls and areas for development and improvement had not been identified. A number of external stakeholders had identified improvements were required in a number of areas, which had resulted in the developing of action plans to bring about improvement. We found some evidence to support that the action plans developed by the external stakeholders were being implemented. The leadership and management of the service were not effective. This directly impacted on the quality of support and care people received and meant they did not experience the best possible health and quality of life outcomes.

The provider's policies and procedures for the governance of the service, with regards to quality assurance, staff supervision and appraisal were not implemented. There had been very limited opportunities for staff to receive feedback about their performance as there were minimal staff supervisions and a lack of regular team meetings. Staff had not had an appraisal and there was no system to assess the competence of staff.

Systems to support staff recruitment were poor as some staff records did not contain the information required to ensure they were appropriate to work within the care sector. The support staff received upon their appointment was haphazard as there was no clear system for the induction of staff. We found no records to evidence staff induction. We found there were sufficient staff to meet people's daily care needs. Staff had received training in a range of topics, however staff had not received training to enable them to support people effectively when their behaviour challenged.

People's needs were not sufficiently assessed before they moved into Andrin House Nursing Home. People's needs were regularly reviewed, however people's care plans and risk assessments were not updated to reflect people's changing needs and referrals to external health care professionals were not always made when a person's needs changed. People did have regular access to a doctor who visited the service regularly at the request of a nurse.

People's views about the service had not been sought and there was no system in place for people to influence or make decisions about their environment and the care they received. People were not supported to have maximum choice and control of their lives and staff did not fully support them in the least restrict way possible; the policies and systems in the service do not support this practice.

People did not receive person centred care; there were institutional approaches and practices to care being observed and documented, which meant people did not receive individualised care or care as detailed within their care plan. We observed some people were encouraged to take part in activities, for example board games or reading a newspaper. However there were a number of people seated in comfy chairs in the communal room, who spent a majority of their day with their eyes shut as there was little to stimulate them.

People's safety could not be assured as records were not always accurate and information staff had access to promote people's safety, which included risk assessment and care plans did not contain sufficient,

consistent or up to date information. People's medicine was managed safely.

People's nutritional needs were assessed however these were not always an accurate reflection of their needs. Records recording people's food and fluid intake were not reviewed to identify whether their food and fluid intake was sufficient for their needs. The dining experience for people was not optimised, with people sitting at the table for lengthy periods of time before their meal was served.

People who used the service and visiting family members spoke positively about the care.

The registered manager of the other service, owned by the provider, had when we returned on 2 May 2018 begun to bring about improvements. The contents of staff files had been reviewed and staff had been informed as to what information was required so that their suitability to work within the care sector could be assured and the required documents kept within their records. A schedule for the supervision of staff had been put in to place.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not safe.

Potential risks to people's safety and welfare were not kept under review and where changes were identified documentation was not updated to promote their safety and welfare.

Staff recruitment practices were not robust. Staff's competence to ensure they promoted people's safety and welfare was not assessed.

Areas for improvement in the prevention and control of infection had been identified by an external stakeholder.

The system to review and analyse accidents and incidents was not consistently implemented or used to improve the safety and welfare of people.

People received their medicine as it was prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The system to assess people's needs was not robust to ensure the best outcome when moving into the service.

A system to support staff through induction, supervision and appraisal was not in place.

People had access to health care services, however in some instances referrals were not made consistent with their care plan.

Areas for improvement in the environment had been identified by an external stakeholder. A number of improvements were being made to the service.

Staff had an awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and its implications for people using the service. DoLS authorisations where appropriate were in place or had been applied for.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The approach of staff towards people was caring and staff were knowledgeable about the people who resided at the service.

Staff approach towards care was often focused on the completion of tasks and did not always consider the individual needs of people.

People and family members spoke positively about the approach of staff toward them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive a service that responded to their care and support needs as care plans did not always contain consistent or accurate information.

Opportunities for people to engage in activities were available. However some people spent their day sitting with their eyes shut in an un-stimulating environment.

People were aware of how to raise a concern and were confident to do so.

No one was receiving end of life care when we inspected the service. People in some instances had their wishes regarding their death recorded within the care plan.

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager was not in post.

The registered person had not kept under review the day to day running of the service, to assure themselves that people using the service achieved the best possible outcome in their care and support.

The registered person did not have systems in place as to the governance of the service. There were no reliable and effective systems to assure people's views were sought or opportunities given to influence the service they received.

The lack of oversight and management of the service had resulted in areas of improvement not being identified. External stakeholders had identified improvements were needed.	

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

Andrin House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

Andrin House Nursing Home accommodates 37 people in one adapted building.

We inspected Andrin House Nursing Home on the 23 April 2018 and the visit was unannounced. We returned to complete our inspection on 24 April and 2 May 2018.

The inspection was carried out by one inspector, a Specialist Advisor (the Specialist Advisor had experience working and caring for people who have nursing needs) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We contacted commissioners (commissioners represent organisations, such as social services who commission services on behalf of people) by e-mail requesting feedback about the service.

We spoke with six people who used the service and the family members of three people who were visiting when we inspected. We spoke with the registered person, a nurse and five members of the care staff. The inspection was facilitated by a registered manager of another care home owned by the provider.

We reviewed the care records of five people who used the service. We looked at six staff records, to evidence their recruitment, induction, on-going monitoring and training. We looked at the minutes of staff meetings and people using the service and their family members. We examined documents which recorded how the provider monitored the quality of the service being provided.

Inadequate

Is the service safe?

Our findings

At our previous inspection of 1 and 14 June 2017 we found the registered person had not ensured that risks to the people using the service were mitigated. We issued a requirement notice as this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had not been made.

The previous inspection found that some people did not have a PEEP (personal emergency evacuation plan) in place. A file was in place which contained risk assessments detailing the level of support a person would require should there be a need to evacuate the service in an emergency. (PEEPs) for four people were inaccurate as one person now occupied a different bedroom. One person did not have a PEEP. This meant people's safety was at risk as appropriate steps had not been undertaken to ensure they were safe in the event of an emergency.

At this inspection people's records detailing their care, were in some instances were not accurate, they provided inconsistent information or the information documented had no obvious meaning and remained unfit for purpose as identified at the previous inspection of June 2017.

We found the initial assessment of a person had not considered their specific needs. The lack of a care plan meant the person's move to the service had not been planned to achieve the best possible outcome for the person. This lack of information and guidance had impacted on the person's care and well-being. The person's initial assessment had taken place three days prior to their moving into the service. At the time of the inspection the person had lived at Andrin House Nursing Home for three days. We observed that when staff were presented with the person displaying behaviour that challenged they did not know how to support the person. The person's behaviour during their period at the service had been responded to by a decision being made that the person moved to another bedroom. This was further confusing for someone living with dementia that had recently moved into the service, which they were unfamiliar with and then moved rooms within a very short period of time.

A moving and handling risk assessment and care plan for a person had not been updated to reflect their needs had changed. The care plan had not been updated to provide information for staff. For example, as to the type of hoist to be used or type and size of sling. There was no current moving and handling risk assessment and therefore no potential risks had been identified. This put the person at risk of not receiving their care safely.

A nutritional risk assessment and care plan for a person was regularly reviewed, however the care plan had not been followed as the person's loss in weight had not resulted in staff seeking the advice of a dietician. The person's care plan for personal hygiene stated, 'if [person's name] reports an issue with their teeth staff to find a community dentist'. The person had been at Andrin House for approximately 6 months and the care plan review had not resulted in the person's care plan being updated, to reflect the information that they had lost their dentures. We spoke with the person and a visiting family member. The person told us. "I don't feel like myself. I feel self-conscious." The person's family member said. "[name] a proud person, and

misses their teeth." The person's care plan stated they had a pre-mashed diet, and that sometimes the person hid their food. The person was prescribed fortifying meal replacements. The records we looked at for the week beginning the 8 April 2018, every day documented that 'small diet taken' or 'no diet taken' (not eaten). We found no evidence to support the person's care plan and daily notes had been reviewed and action taken. For example the person had not been asked if they wished to have new dentures or attended an appointment with a dentist.

Staff had completed a falls risk assessment for a person, which they had adapted to include options and scores which were not part of the form guidance. This meant the person's total score to determine the level of risk of falling was not accurate.

A second person's waterlow risk assessment (a tool used to determine the level of risk of a person developing a pressure sore) had been completed incorrectly. The person's weight used to calculate the level of risk was not awarded the appropriate score, this meant the person had been assessed as 'high risk', when if completed accurately would have identified they were at 'very high risk'. The weight of the person had been reported consistently low but the waterlow assessment had stated they were average. The documentation had been completed inaccurately on a monthly basis, on the same date since 6 October 2017. The implications of an incorrect score can affect the management of the person's care. If someone's waterlow is a very high risk, staff should ensure the person has pressure relieving equipment and receives additional support with their repositioning. The person was repositioned regularly

A person had a pressure relieving mattress on their bed to help prevent the development of pressure sores; however this was not used correctly. The pressure of the mattress should be set dependent upon the person's weight. The person's weight was recorded at 49kg; however the pressure of the mattress was set for someone in excess of 140kg. There was no procedure to check whether pressure relieving mattresses were correctly set.

Staff were not confident that they had the necessary skills to support people whose behaviour challenged others. We observed staff respond to a person, the response of staff to the person was not effective. A member of staff sought guidance from a registered manager (the registered manager of the registered person's other service) who was facilitating the inspection. They instructed the staff to move away from the person. The registered manager spoke with the person and calmed the situation. When we spoke with staff, they told us they had not received training on how to support people whose behaviour could challenge. The person did not have a risk assessment or care plan for any aspect of their care for staff to refer to.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

The previous inspection of June 2017 had identified that people who had medicine that was prescribed to be taken as when required did not have a protocol in place, specifying the circumstances in which the medicine should be administered. We found protocols were in place.

People in some instances were prescribed creams, separate charts completed by care staff recorded when the creams had been applied. The two people's records we looked at were incorrect. The directions for one person's cream stated it should be applied every 3rd wash or every 72 hours, however the records showed the cream had not been applied consistent with the prescribers instructions.

Drugs which require a higher level of monitoring and care should be disposed of in a specified manner. We found these medicines were clearly labelled; however there was not a 'denaturing kit' (used for the disposal

certain medicines to ensure they cannot be reused). Nursing staff were unsure about the safe disposal of these medicines.

All medication stored within the two medicine trolleys was in date and items had been labelled with the opening day, this included, inhalers, liquids and oral medication. There was a BNF (British National Formulary – pharmaceutical reference book) on one of the trolleys but this was dated September 2013 – March 2014. The BNF is issued twice a year and out of date copies should be destroyed.

People's safety was compromised as the registered person did not have a robust recruitment process for staff. Staff files did not contain all the information required. Application forms were not always dated or signed. One staff member's contract of employment was dated, a day prior to the date on their application form. There was no evidence as to the interview process, questions posed or information as to the rationale used to determine the person's suitability for the role applied for. One staff members file did not contain any references and the application form did not provide a full employment history or two forms of identification. A second staff file did not contain a reference from their previous employer; their employment had been based on character references. A third staff members file, did not contain confirmation of their identity, including a photograph. A reference from their current or previous employer was not in place; their employment had been based on character references. Some staff did not have a contract of employment. All staff had a Disclosure and Barring (DBS) check; however these had not been reviewed. For nurses, a check of their Nursing and Midwifery Council registration had been carried out.

We found people were at risk as there was no consistent approach to the induction of new staff and there was no documentary evidence to support staff had undergone an induction into the service. For example, for a nurse who had recently been employed, records did not provide any information as to their induction. We were told by the nurse and others that the nurse worked alongside other nurses to gain experience. On the afternoon of the first day of our site visit, the nurse was left in charge of the service. We spoke with the registered person as to the lack of evidence to support their induction and that the nurse had worked without another nurse being on duty. The registered person said the manager had assured them that they would not be working alone and that the nurse on duty the day previously should not have gone off duty leaving the other nurse unsupervised.

We sought the views of people using the service about staffing levels and whether they received support and care when they needed it. One person explained that staff response to answering their buzzer was dependent upon how busy staff were. They said. "They're always short staffed." A second person told us the staffing levels were adequate but went onto say. "Too few people to do all the jobs." They said they needed assistance in the morning to get up, they said they didn't use the buzzer and that they were, "Content to wait to be hoisted."

A lead nurse for infection prevention and control on behalf of NHS Erewash & NHS Southern Derbyshire Clinical Commissioning Group (CCG) carried out an audit in January 2018. A range of shortfalls were identified. The registered person was provided with an action plan detailing the requirement and action to be taken and the person responsible. The action plan which we looked at had not been updated by the registered person or manager as to what action if any had been taken. The action plan will be monitored by the CCG's.

A meeting involving catering staff was held in January 2018, where the report written by the lead nurse for infection prevention and control on behalf of the CCG's was discussed. Staff were informed that the kitchen door was not to be propped open. The door was not open when we inspected the service. It was stated that improvements as to greater detail was required when completing people's charts to record their fluid intake.

Staff were reminded that the temperature of the fridge was to be recorded, items once opened should be date labelled when placed in the refrigerator and improvements were needed to the variety of puddings and snacks for people who required a soft diet.

The registered person and manager had not taken appropriate actions as a result of learning from incidents. Analysis of incidents and accidents had not taken place since November 2017. The most recent analysis had identified that incidents involving people using the service took place when staff were not on 'the shop floor'. However the analysis did not identify what action if any had been undertaken as a result of the audit.

People told us they felt safe. One person when asked how safe they were in the service told us they preferred to spend their time in their room. They said. "I'm better off here." A second person when asked if they felt safe told us. "Because I feel safe." A third person described being safe as "utterly." We asked family members for their views as to their relative's safety at the service. A family member said. "He hasn't fallen and he's turned at night. They give him fleece gloves to stop him hurting his hands."

Andrin House had a range of equipment to assist people with their day to day lives. For example, profile beds, hoists, stand aids and assisted baths. We found a contractor had visited the service to check the safety of the equipment. Documentation of the contractors visit was in place and showed a range of equipment had been repaired. The documentation also showed equipment had been decommissioned as it was unsafe; this included a bed and a hoist.

Derbyshire Fire and Rescue had visited the premises in August 2017. They found 'reasonable standard of safety' and had identified action points for the registered person. We found no records to support if any action had been taken.

We found there were sufficient staff on duty to meet people's needs. A member of staff was always based in the lounge and dining room area, so that people were monitored continually which enabled staff to respond if it should have required. There were four care staff on duty and a nurse throughout the day, and a nurse supported by two or three care staff during the night.

We found medicines were stored in line with current national guidance; the treatment room was locked when not in use and the nurse in charge held the keys. The temperature of the fridge to store medicines along with the temperature of the room were checked on a daily basis and were within the desired ranges.

People's allergies were clearly labelled on people's MAR's. People were supported to take their medications safely, there is a staff sample of signatures within the Medication Administration Records (MARs) and there was a recent photograph of each person on the MARs from the supplying chemist. Staff did not sign the MARs until the person had taken the medicine which was observed by the nurse.

The registered manager of the other service who facilitated the inspection had said they were committed to bringing about improvements. With the support of a nurse and senior care assistant actions to bring about improvement had been initiated. The contents of staff files had been reviewed, and documents that were missing identified. A schedule of one to one meetings with staff over a two day period was being introduced. The purpose of the meetings was for staff to bring with them any documents that were missing from their file. The registered manager stated staff that did not have a contract of employment would be issued with one at this meeting.

Staff had received training as to their responsibility in reporting and recognising potential or actual abuse. Our discussions with staff showed staff were knowledgeable about who they should contact if they had any

concerns, which included organisation such as the CQC. A night staff meeting held in February 2018 had been used to inform staff that where injuries, such as bruising or skin tears were noted these should be documented on a 'body chart'. The meeting referenced a safeguarding concern, where a person had sustained injuries which had resulted in them going to hospital. The safeguarding investigation had identified documentation as to the persons injuries had not been completed well, which meant an audit trail as to the events leading up to the person's need to go to hospital was not easily identified.

Requires Improvement

Is the service effective?

Our findings

We looked at the records of a person who had moved to Andrin House Nursing Home three days prior to our inspection. An initial assessment had been undertaken of their needs, which had recorded basic information about their needs, such as their name, date of birth, current prescribed medicines. Basic information as to known health conditions, such as being diabetic and living with dementia, the person's weight, dietary requirements and information as to a known behaviour that challenges others. The person's assessment had not focused on gaining information about the person, such as their hobbies and interests, family or work life. We found no evidence that the move of the person had been planned for with regards to the person's wellbeing, to ensure the move from one service into Andrin House Nursing Home was a positive experience.

Staff told us they had a period of induction, which included working alongside experienced members of staff. As part of their induction staff said they completed on-line training in a range of topics. The registered person was not aware of the Care Certificate and no staff had attained this award. The Care Certificate is a set of nationally recognised standards which supports staff working in care and support to develop the skills, knowledge and behaviours needed in their roles.

We looked at staff records in relation to supervision and appraisal. We found the provider's policy and procedure for staff supervision had not been implemented, which stated staff to be supervised for a minimum of four times a year and to receive an annual appraisal. The frequency of staff supervisions was intermittent and infrequent and the written records of staff supervision contained minimal information. Supervisions and appraisals provide an opportunity for staff to receive feedback about their work and to plan and review their training and development. There was no evidence of staff having received an annual appraisal.

These are breaches of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Staff we spoke with told us they accessed training through 'social care TV', this is on-line training, which staff completed when there were off duty, and at home. Staff told us topics of training included fire awareness, health and safety and infection control. Records showed staff training was up to date, with the exception of one member of staff. The registered manager (the registered manager of the registered person's other service) who was facilitating the inspection, informed us they would ensure the staff member undertook the training required.

Staff received a majority of their training through 'social care TV'. Staff told us that they watched a presentation and then answered questions. Staff files contained copies of their certificates. Staff told us some training was interactive, which they received in a 'classroom style' setting. This included moving and handling people safely; using a hoist and other equipment. A member of staff told us that they would benefit from comprehensive training in how to care and support people living with dementia, including how to manage people whose behaviour challenges.

A person's nutritional care plan stated they were to be offered fortified snacks between meal times at 11 am and 3pm and that their dietary intake was to be documented. The person's dietary intake was recorded, however the level of information provided made it impossible to determine how much the person had eaten, as the portion size was not detailed. There was no evidence that the information was used to review the person's care plan and the care they received. We looked at the person's records which showed they had maintained a steady weight. We asked the nurse on duty about the person's records to evidence they were provided with fortified snacks. We were told the person no longer had a fortified diet. The person's care plan had not been updated to reflect this.

A number of people had their dietary intake recorded. Records however did not provide sufficient information to determine whether people were eating and drinking sufficiently. Records for example, stated. 'Ate half of their meal'. However there was no information as to the size of the portion.

People's records contained information about MUST (nutritional assessment tool), but the tool its self was not in place. Information to record people's BMI (body mass index) was in place, however information gathered by completing documentation was conflicting, which meant it was unclear as to the care and treatment a person may need. For example one person's score outcome was different to that recorded by the dietician. The person had remained a constant weight since October 2017. The registered manager facilitating the inspection, informed us that the document used by dieticians and the service had a different scoring system. They said they planned to introduce the tool used by dieticians into the service for consistency.

We observed the dining experience for people; we found this to be a task to be completed as opposed to people's dining experience being considered. Staff began to assist people to one of the dining tables at 12:10; the serving of the meal began at 12:30, which meant people were sat at a dining table for a lengthy period of time; some people who sat were sitting at the dining table, had their eyes shut. People in some instances were asked if they wanted to wear an apron, however staff in some instances put an apron on people without asking the person. Most people's meals were served by 12:50 and desserts started to be served at 1pm. People were served hot drinks and they began returning to their comfy chairs at 1.15pm with the assistance of staff. One person was heard to make negative comments about their meal and staff sought an alternative for them. We noted a majority of people ate their meal.

People told us they had plenty to eat and drink. A person said. "The food is very nice; I get plenty of tea and juice." A second person told us they had breakfast whenever they wanted it and had plenty to drink; they told us the food was good. "I like all food." They went onto say their favourite meal was. "Fish and chips." A third person described the food as canteen standard and that there was always a choice and that there was plenty to drink. A fourth person said they were diabetic and that their diet was adjusted accordingly. They said they had plenty to drink, and that at the weekend they were provided with a full cooked breakfast. A family member told us their relative was on a pureed diet and received thickeners in their food and drink. They went onto say that their relative ate well and had arranged with the service that they would visit Andrin House Nursing Home to help support family member to eat as this was something they wished to do. A second family member confirmed that the food was good and that there was plenty to drink.

A person using the service received their nutritional supplements via an alternative method, known as a PEG (percutaneous endoscopic gastrostomy) which means their nutrition is passed via a tube directly into the stomach. We found the person's care plan to be clear and advised staff on the correct fluid intake each day.

The menu was displayed in writing on each table for each mealtime. We observed positive interactions between people and staff during the lunchtime meal. Staff asked people what they wished to eat and staff

supported people to eat their meal where necessary. Staff sat at people's eye level when assisting them, and the support provided was at the person's own pace. One person told us they preferred to eat their meals in their bedroom; we saw staff throughout our inspection taking the person food and drink to their room.

Staff we spoke with were aware of the needs of people using the service; they were able to talk to us about their individual care and support. A member of staff told us that when people's needs significantly changes an 'emergency meeting' was held. They provided an example of where staff had been asked to encourage a person to eat and drink and record the person's food and fluid intake. The member of staff said records of the meeting were not made.

Staff spoke of their attendance at daily handover meetings, where each person using the service is discussed and any updates about the person were shared. We looked at the records completed at handover, and found these were very basic, and could not be relied upon to provide information as to what issues were discussed or of any action to be taken.

Nurses took responsibility for the development and reviewing of people's records. Staff (care staff) told us they informed nurses of any changes in people's well-being and that nurses would then update people's records. A member of staff told us they did not look at the care plans and that they had no involvement in the writing or reviewing of these. They went onto say that not all paperwork was completed as it should be.

We spoke with people about their access to health care services. One person told us they saw a health care professional regularly as they required their 'dressing' to be changed every other day. They described the nursing care as. "Pretty darn good." A second person told us they had regular visits from an optician who had prescribed glasses for them. A family member told us the nursing care at the service was good and that staff would suggest calling a GP if their relative appeared poorly. A second family member said staff were attentive to their relatives health needs and were good at noticing when they became unwell. They spoke of an occasion when they had recently become concerned about their relative and had referred them to the GP.

We heard the nurse contact the local surgery to request a visit by a GP to the service. The nurse provided the names and general information about their concerns; we saw that the GP visited people later that day. People's records contained information about the involvement of health care professionals in their care and treatment.

Staff in the main spoke positively about the management of the service, saying there was good leadership and that they responded to issues straight away. For example, a member of staff told us that if they had concerns about a person's health they reported their concerns to the nurse who took action.

A recent visit by commissioners of social care had identified improvements were needed to the environment. An action plan, to be monitored by the commissioners had been given to the provider, detailing the improvements required. We found the refurbishment of some bedrooms was in progress, bedrooms were being decorated and new carpets fitted. There was no evidence that people using the service had been involved in decisions as to how their room was decorated. We found the same designs of wallpaper being used in bedrooms. The nurse on duty told us staff had chosen the décor. A ground floor bathroom was being altered into a 'wet room'. The nurse told us of additional improvements which were planned as a result of the commissioners visit included the refurbishment of the kitchen and new windows to some areas of the service.

Andrin House Nursing Home had a lounge and dining area, this was the central point where people spent

their day. There was a quiet lounge and activities room on the ground floor, however their use was minimal. The main lounge and dining area did not provide a stimulating environment for people. There was minimal environmental stimulation provided. Comfy chairs were positioned to face a wall, which had a small television mounted on a wall; either side of the television was a medicine cabinet, whilst seating arrangements for others meant their view was a large window looking into the office. To the rear of the lounge, the comfy chairs were arranged so people sat opposite each other.

There was an outside garden, however this was not well maintained and access to the area for people with mobility difficulties was hampered by uneven paving. The wooden frame of the patio door, leading from the lounge into the garden was rotten, and had been identified by commissioners as needing replacing. The nurse told us that improvements were being planned for the garden, which included a memorial garden. There was no evidence as to people's involvement in decisions about the garden and there was no plan as to how improvements were to be brought about or when.

Commissioners had identified that the service did not have signage to support people in orientating themselves within Andrin House Nursing Home. We found signs indicating the dining room, lounge, toilets and bathrooms had been put into place.

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. Whey they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation process for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There were four people who had a DoLS authorisation in place, of which none had conditions attached. The manager had re-applied for some people's DoLS as they had expired.

Staff we spoke with were aware of those people who had an authorised DoLS in place and had an awareness of the MCA.

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the standard of care provided. One person said. "Nothing is too much trouble, they (staff) look after me well, they're very good, I have a laugh with the girls. I'm happy with my lot, it's brilliant and it's lovely." A second person said. "It's alright, you can talk to them (staff), they take care of you." A third person said. "I'm glad I came here, it's exemplary the staff are exceptional. [friends' name] says this is the best in Derbyshire." A family member said. "They (staff) shower him and me with respect. I find them lovely to speak to, he doesn't need a posh place, it's the care that's important. I don't care about fancy things, seems like a little family. It's lovely everyone speaks to everyone. I'm quite happy, he (relative) seems quite happy, nothing should change."

Staff knew people well and their relatives. We saw examples of positive interactions between staff and those using the service, for example staff spent time with people engaging them in activities, which included a brief conversation about items in a national newspaper. Staff were seen to spend time with people who used the service who were able to converse, sharing a joke and asking after their welfare. People were routinely offered refreshments and staff when serving drinks asked people what they wished to drink, and whether they wanted a biscuit.

We asked staff about the vision and values of the service. One member of staff told us it was for staff to encourage people's independence. For example, by supporting them to wash their face and hands. We asked a member of staff what equality and diversity meant to them. They told us it was to make sure people were well cared for and the care was what the person wanted and not for staff to assume.

People's views had been incorporated into their care plans as they contained some information about their interests, for example. One person's care plan stated they enjoyed socialising and watching the television and in particular enjoyed watching mysteries and dramas and listening to classical music. The person's care plan had been signed by a family member in September 2015.

People's dignity was not always respected, as staff's approach to the delivery of people's care and support was focused on the completion of tasks and did not always consider each person individually. For example, people wore aprons at lunchtime irrespective of whether they wished to. We noted staff in some instances approached people to provide personal support, for example moving them from a comfy chair into a wheelchair by use of a hoist. Staff did not always speak with the person, to tell them what they were about to do.

The approach to people's care had been documented in a recent staff meeting. We found in some instances staff were being instructed to provide personal care reflective of the day to day running of the service as opposed to people's wishes. For example, a night staff meeting held in February 2018 stated. 'Due to the numbers of residents we have three baths/showers have been added to the night routine weekly'. A staff meeting for care staff held in March 2018 had recorded staff approach to people's care, which supported our observations of a task orientated environment. The minutes stated. 'At present there are a few staff who do not care for residents, who appear to be telling the carers what do to and how to do it. It has been noted

some carers are rushing through their tasks'.

People we spoke with said staff respected them and upheld their wishes. One person said they had access to baths and showers but felt they didn't like either and preferred an "all over wash." They said staff respected their wishes. A family member said there had a weekly visit from a Priest each week to provide Holy Communion for their relative.

Requires Improvement

Is the service responsive?

Our findings

People's care plans covered a range of topics, which included their communication needs, personal hygiene requirements, mobility, nutrition, pressure area care, sleeping and medication. Of the records we looked at we found some people's had been updated in the last month and on the same date since October 2017.

We found the day to day running of the service to be task orientated, in that we saw people following a set routine, which included being seated at one of the dining tables prior to lunch and tea time, in some instances for up to 30 minutes until the meal was served. On the first day of the inspection we asked why a person was sitting at the dining table in a wheelchair. The person was leaning to one side and there was nothing on the dining table for them to occupy themselves with. Staff told us the person had just had a shower and they were waiting for the teatime meal, which would be served 45 minutes later. A registered manager informed the member of staff that the wheelchair being used was only for the purpose of transferring and should not be used for any period of time to sit in. A registered manager (the registered manager of the registered person's other service) who was facilitating the inspection spoke with the person and asked them if they were comfortable, to which the person replied. "My back aches." The registered manager asked if they wished to sit in a comfy chair, to which they replied yes. The member of staff then with the assistance of another member of staff hoisted the person into a comfy chair.

We saw people were able to move around the ground floor, however most people appeared to be 'parked' in the main lounge in two 'horse shoe' shapes, sitting often leaning to one side and with their eyes closed. Whilst some people sat for long periods at one of the dining tables, some people chose to remain sitting at a dining table, however there wasn't always something for them to occupy themselves with. Staff did support some people in taking part in activities, this included colouring and playing board games, such as drafts and dominoes. A few people occupied themselves by reading.

A person had a care plan for the health condition of epilepsy which was dated 6 April 2017. It stated that 'after having a seizure [person's name] to sleep quietly in a darkened room'. And, 'if [person's name] seizure lasts longer than 5 minutes the emergency service needs to be called.' The persons care plan reviewed on 6 March 2017 stated the person had had 'some jerky episodes this month' and 6 February 2017 it stated 'medication given as prescribed.' There was no guidance for staff to record the time of the seizure or whether to inform the person's doctor. The person's care plan did not detail how the person should be cared for during a seizure, for example being placed into the recovery position. It was not clear as to how stable the person's epilepsy was.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Person centred care.

We asked people as to how they occupied themselves. One person told us they preferred their own company and had items in their room to keep them occupied. They said they enjoyed watching the television. They told us a 'maintenance man' had bought them a television, however they couldn't get on with it and so they purchased another model. They told us they appreciated the effort the 'maintenance

man' had gone to on their behalf. They went onto say that they had daily newspaper delivered and they enjoyed doing the crossword. Staff had supported them in having a landline installed and that they had been able to keep the same telephone number they had prior to them moving into Andrin House Nursing Home. The person referred to their telephone as. "It's my lifeline." A second person told us they enjoyed listening to music. A third person told us they enjoyed reading and shared with us the book they were currently reading and said they had a newspaper delivered daily. They told us. "I've never been bored here one day." They went on to say that they had regular entertainment provided in the form of singers and other entertainers. A fourth person told us they enjoyed reading and watching the television. They went onto say. "Once a month there is entertainment."

A senior carer, three days a week, between the hours of 9am to 3pm had the role of activity organiser. We saw the activities room, which was a large room on the ground floor. The room contained a range of games, board games and creative equipment, such as paint. We were told that people were encouraged to the use the room. The room contained art work completed by people at the service, which was displayed on the wall.

A family member said staff at the service were good at responding to issues. They said. "If I mention any concerns such as [relative's] eyes, they respond quickly."

One complaint had been received in 2017. The complaint had been documented and a letter of apology sent to the complainant. Prior to this the most recent complaint recorded was in November 2015. People told us they would speak with the manager if they had any concerns.

At the time of inspection no one was receiving End of Life Care. We found in some instances people had a funeral plan in place. We found no information in people's records as to their preferences in relation to End of Life Care, such as their preferred place of care or death.

For people who do not wish to be resuscitated, Do Not Attempt Cardio Pulmonary Resuscitation. (DNACPR) forms recorded their wishes, and had been signed by the appropriate health care professional and were kept at the front of the person's records. To support people in end of life care, 'anticipatory medicines' were prescribed, one person had these medicines in place should they be required to manage their symptoms and pain.

Inadequate

Is the service well-led?

Our findings

There was not a registered manager at Andrin House. Andrin House Nursing Home has not had a registered manager in post since 18 February 2016. The inspection was facilitated by a registered manager of another care home owned by the provider. The manager of Andrin House Nursing Home was on leave at the time of the inspection. At the inspection in June 2017 the provider told us they were in the process of recruiting a manager for the service who would be registered with CQC. It is a condition of the provider's registration that a registered manager is in place. An application was not submitted.

The Care Quality Commission (CQC) wrote to the registered person on 13 March 2018 to advise them they were in breach of their conditions of registration. The registered person and manager of the service have said that an application will be submitted when the manager has acquired the documentation to support their application to CQC. An application has not been submitted.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

At our previous inspection of 1 and 14 June 2017 we found the provider's systems and processes to monitor the quality of the service to ensure compliance were not effective. We issued a requirement notice as this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had not been made.

At this inspection we found the registered person and manager had not kept under review the attitude and approach of staff to ensure they had a positive impact on people. A staff meeting held in March 2018 had been used as a reminder for staff of confidentiality, having identified that some people using the service and their family members were very aware of staff's personal problems. Opportunities were not put in place for staff to receive feedback about their work or to identify and explore development opportunities. The provider's supervision policy was not followed. Staff up until recently had not been regularly supervised. There were no records to support staff had had an appraisal.

The registered person and manager had not implemented systems or processes to monitor the quality of the service. The policy for quality assurance stated surveys to ascertain people's views, which included people who used the service, their family members and stakeholders would be circulated annually. We found no records to support people's views had been sought. The quality assurance policy referred to regular meetings to be held with people using the service and family members. The most recent meeting involving people who use the service had taken place in September 2015. For family members the most recent meeting was held in February 2018. Prior to this the most recent meeting had been held in September 2016.

An annual development plan to identify improvement was not in place and was a further example of the quality assurance policy not being implemented. A lack of planning and oversight as to the quality of the service being provided meant shortfalls had not been identified, which meant opportunities to make improvements had been missed. The registered person was not proactive in their response to promoting

people's safety as systems were not in place to ensure risk assessments were regularly reviewed and updated. Systems to internally monitor the safety of equipment were not in place, this had resulted in external contractors decommissioning some equipment as it was unsafe to use.

Recent visits by external stakeholders for both health and social care had identified improvements were needed. Action plans, to be monitored by the external stakeholders had been given to the provider, detailing the improvements required. We found the action plan for infection control improvement had not been updated to identify what action if any had been undertaken. We found some actions had been undertaken in response to the audit carried out by commissioners. For example, staff meetings had taken place and improvements were being made to maintain and improve the environment.

The registered person and manager had not ensured an open and inclusive environment for staff to work, or provided opportunities for staff to share ideas and develop the service. Meetings involving staff had been infrequent. Meetings involving all staff, with differing roles and responsibilities had taken place between January and March 2018. Prior to these meetings for staff had not been regularly held, for some staff this was for a period in excess of two years. The minutes of recent meetings had identified areas for improvement, however no dates had been set for future staff meetings to review the points raised to review whether improvements had been made. For example, the minutes for a care staff meeting dated March 2018 stated. 'It has been noted that some residents who have a poor appetite and eat very little are not always encouraged and prompted with eating and some staff have been told not to give drinks to these residents before meals as they may not attempt to eat. All residents can have drinks or snacks at anytime.'

The approach towards audits to monitor the quality of the service were haphazard in their application and improvements identified were not recorded as being actioned. A system to audit and analyse accidents and incidents within the service had been undertaken monthly, however the most recent audit was dated November 2017. The outcome of the audit for November 2017 identified 'majority of incidents occur when most staff are off the floor'; as a result of this audit we found no written evidence to support any action had been undertaken. We found accidents and incidents had occurred since November 2017 to the current date these had not be analysed.

The system to audit medication had commenced in November 2016, however the most recent audit was dated January 2018, there was no explanation as to why audits no longer took place. An independent organisation had carried out a comprehensive medication audit in October 2017, at which areas for improvement had been identified. There was no documentary evidence to support whether improvements had been made.

The registered person visited the service; however there was no evidence that the registered person monitored the quality of the service by undertaking any quality assurance checks themselves. There was no written record detailing who they had spoken with, the purpose or outcome of their visit. The registered person relied upon the manager to monitor the service.

The business continuity plan developed for the service was dated 2016 and had not been reviewed or updated.

Policies and procedures had been reviewed, however they were not implemented, which included the provider's for quality assurance policy.

These matters evidence a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider is required to display the rating following CQC inspections, both within the service and where applicable on their web profile. Andrin House displayed their rating within the service. The provider does not have a web profile.

We spoke with the registered person who confirmed they regularly visited the service. We spoke with the registered person, who confirmed that the registered manager of the other service would remain and oversee the day to day management of the service whilst the manager of Andrin House Nursing Home was on leave. The registered person said they would be speaking with the registered manager to ask them to remain at Andrin House Nursing Home upon the managers' return to offer support; the specific details and length of support were not clarified at the time of the inspection.

The registered manager of the other service who facilitated the inspection had said they were committed to bringing out improvements. With the support of a nurse and senior care assistant actions to bring about improvement had been initiated. The contents of staff files had been reviewed, and documents that were missing identified. A plan of one to one meetings with staff over a two day period was being introduced. The purpose of the meetings were for staff to bring with them any documents that were missing from their file. The registered manager stated staff that did not have a contract employment would be issued with one at this meeting. The registered manager during our visit had developed a schedule of audits to be undertaken in a range of areas.

The registered manager brought examples, from their service, of care plans covering a range of topics that they would introduce at Andrin House Nursing Home. At the time of the inspection we found significant shortfalls in people's care plans and documentation recording people's care and support.

Staff in the main spoke positively about the management of the service. Staff said the manager was approachable, and that staff got on with each other. One staff member said. "It's a nice place to work, all in all."

We sought the views of people and family members as to the management of the service. One person told us their room was close to the office used by the owners (registered person) of the service. They went onto say that they found them to be approachable and that they spoke with them most weeks. A second person said of the leadership and management. "Invisible, but clever. People do what is asked of them. The manager is approachable, they listen. They spoke of a nurse saying. [nurses' name] is a delight."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider had failed to comply with the conditions of their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care and treatment of people was appropriate, met their needs and reflected their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure effective recruitment procedures, which included adhering to schedule 3.