Oakfoil Limited

St Andrews House

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

Summary of findings

Overall summary

We carried out an inspection of St Andrews House on 1, 2 and 11 August 2017. The first day was unannounced.

St Andrew's House provides accommodation and both nursing and personal care for 24 people who have a physical disability. It is an extended, detached older property located in the town centre of Barnoldswick. Accommodation was provided on two floors with a passenger lift. There were 17 people accommodated in the home at the time of the inspection.

At the previous inspection on 13 July 2016 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to infection control practices, safeguarding vulnerable adults, training and induction and quality assurance processes. We also made recommendations about the provision of consistent numbers of staff and improving the recruitment process and medicine management processes. Following the inspection we asked the provider to take action to make improvements and to send us an action plan.

During this inspection we found there had been limited progress made in respect of infection control practices and with quality monitoring systems. We found seven breaches of regulation in respect of infection control, recruitment processes, maintaining the environment, medicines management, care planning and risk assessment and quality assurance systems. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At the time of our inspection the service did not have a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had been a change to the registered manager since our last inspection. The previous registered manager had left the service in July 2016. The current manager had been in post since May 2017.

People considered there had been times when there had not been sufficient staff to meet their needs. We found sufficient numbers of staff however, the numbers of available staff varied from day to day which had impacted on people's support. Changes to the staff team had created shortfalls and meant a high reliance on agency staff was necessary. We were told recruitment of additional staff was underway.

A safe recruitment process had not always been followed. Staff had received a range of training although were not suitably supervised. People's medicines were not always managed safely.

People were happy with their bedrooms. However improvements were needed to the home to ensure it was suitable, clean and comfortable. Appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort.

New systems to monitor the quality of the home had been introduced but had not been effective. We found a number of areas in need of improvement. In addition the systems to seek people's views about the home needed to be improved particularly in light of people's level of unhappiness. We found there had been a lack of communication which had created unsettlement and anxiety for people. People were unclear who was in charge and recent communication difficulties between the management team and some of the staff were impacting on the care and support that people received.

Safeguarding adults' procedures were in place and were being updated. People's complaints had been appropriately responded to. People were relaxed in the company of staff and were supported to maintain contact with friends and relatives. During our visits we found staff were respectful to people and treated them well.

People were able to participate in a wide range of external leisure activities in line with their interests and preferences. However the provision of activities inside the home was limited. A designated activities person had been recruited following the inspection.

People had choice and control over their lives and staff supported them to be independent in the least restrictive way possible. People's capacity to make their own decisions had not been assessed or recorded in line with the requirements of the Mental Capacity Act 2005.

The information in people's care plans had not been kept up to date and any risks to their health and safety had not always been managed safely. People were not formally involved in reviews of their care plan although were involved in discussions and decisions about their care. People were supported to access health care and the relevant health and social care professionals provided advice and support when people's needs changed.

People were aware of how to raise their concerns and their complaints were appropriately responded to.

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

People generally felt safe in the home but were worried about staff who did not know them.

A number of areas of the home were unclean and untidy which presented a risk of infection.

The level of risk to people's safety had not always been assessed, recorded or kept up to date.

Staff were not always deployed in sufficient numbers to ensure people's needs were met in a consistent way. Safe recruitment practices were not followed.

People's medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were provided with training and professional development. Staff were not provided with one to one support and supervision.

Staff had received training to improve their understanding of the MCA 2005 legislation. However, people's capacity to make safe decisions and consent to care needed to be clearly assessed and recorded.

People told us they enjoyed the meals and could have alternatives if the wished.

The home needed improving and was not properly maintained.

Is the service caring?

Good

The service was caring.

We observed good relationships between people using the service and staff and permanent staff had a good knowledge of people's needs and preferences.

People's rights to privacy were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported to take part in suitable activities outside the home although internal activities needed to improve.

Each person had a care plan that was personal to them. However, we found they were not always accurate and up to date and people had not been involved in formal discussions and reviews of their care.

People had access to information about how to complain but were unsure who to complain to.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager. We found a number of breaches of the regulations.

There were communication difficulties between the management team and some staff which impacted on the ability to improve the service and on people living in the home.

New systems to monitor the quality of the service had been introduced but needed to be embedded to ensure their effectiveness.

People were unsettled and anxious. There had been a lack of effective communication about changes in the home.

Records were not accurate or stored confidentially.

St Andrews House

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.

This inspection took place on 1, 2 and 11 August 2017. The first day was unannounced. The inspection was carried out by one adult social care inspector and included a specialist advisor on the first day. The specialist advisor was a nurse and had personal experience of supporting people who used this type of care service.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. A notification is information about important events which the service is required to send us by law.

Prior to the inspection visit we received concerning information relating to how the service maintained records such as support plans and risk assessments and the cleanliness and standard of the environment. The local authority contract monitoring team and local commissioning teams provided us with information about the service.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the provider, the manager, the clinical support manager, three nurses and two care staff. We spoke with four people living in the home. Following the inspection we spoke with three relatives, two health and social care professionals and the local authority infection control lead nurse.

We looked at a sample of records including four people's care plans and other associated documentation, four staff recruitment and induction records, staffing rotas, training and supervision records, minutes from meetings, complaints and compliments records, medication records, maintenance certificates, policies and procedures and quality assurance audits. We also looked at the results from the most recent customer satisfaction survey.

We observed care and support in the communal and dining room areas during the visit and undertook a tour of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the provider had failed to ensure people were protected against the risks associated with poor infection control. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found areas of the home were unclean and staff had not received appropriate training. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found that not all the necessary improvements had been made. We looked around the home and looked at the arrangements for keeping the service clean and hygienic. We found a number of areas of the home were unclean which presented a risk of infection. We found the ground floor sluice was malodourous, the sink was dirty and the door was open causing an unpleasant odour on the corridor near to people's bedrooms. The clinical waste bin in the first floor sluice was not covered; this was also malodourous. There were unclean flower vases stored in the cupboards. Male urinals were stained, the specialised bath enamel was scuffed and woodwork in all areas was damaged. The downstairs toilet was malodourous, the toilet base and the flooring were damaged. Pipe work and skirting boards were dirty.

The home was very untidy and cluttered with unused and broken furniture and equipment stored in many areas. Cardboard was being stored in an empty bedroom and in the gym/spa room. By the end of our inspection we found broken and damaged furniture and equipment had been removed from these areas. Linen skips were stored on the main corridor. We saw a dirty mattress and dirty floor in an empty bedroom. We discussed this with the manager and appropriate action was taken. We also saw dirty tubing in use on the suction machine; a replacement machine and tubing was delivered during our inspection.

Staff hand washing facilities, such as liquid soap, paper towels and pedal operated waste bins had been provided in most rooms. This ensured staff were able to wash their hands before and after delivering care to help prevent the spread of infection. Further bins were being provided to reduce the risk of cross infection. Prior to the inspection we were told appropriate protective clothing, such as gloves and aprons, were not always available. The manager told us they had recently changed the supplier to prevent this occurring again. Gloves and aprons were seen in use around the home during the inspection.

There were contractual arrangements for the safe disposal of waste. We looked in the basement laundry room; we found some wall repairs had been attended to and a clean hand wash basin had been provided since our last inspection. However, the areas to the rear of the dryers remained in poor condition making it difficult to clean. The boiler room was dirty with dust and debris in all areas.

Relatives said, "There were problems with the cleaners and the home became dirty very quickly" and "[My family members] room was dirty so I was on my hands and knees washing the floor. It was all gungy down the side of the bed. It needs bottoming out and a good clean." A staff member said, "The place is not clean these days."

The provider had failed to ensure people were protected against the risks associated with poor infection

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

A domestic and a laundry person worked each day. Additional domestic staff were being recruited. We noted the cleaning schedules were lacking in detail. However, we were shown an example of the new schedules which were due to be introduced which were more detailed. New audit systems had recently been introduced and would help improve standards of cleanliness. The local authority infection prevention and control lead nurse visited the service on the second day of our inspection; she provided the manager and staff with advice and support on the day and would develop an action plan to support the home with needed improvements.

Records showed 21 of the 34 staff had received infection prevention and control training. Further training sessions were being planned. Infection control policies and procedures had recently been revised although had not yet been shared with staff. The newly appointed housekeeper had been nominated as the infection control lead; she was responsible for all checks and audits and would attend local update meetings.

At our last inspection, we found the provider had failed to establish and operate systems and processes to prevent abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff had not received appropriate training to help them recognise and respond to any abuse or neglect. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection, we found there were safeguarding vulnerable adults procedures and 'whistle blowing' (reporting poor practice) procedures for staff to refer to. We were told the policies and procedures were being reviewed and would be shared with staff. Safeguarding vulnerable adult's procedures provided staff with guidance to help them protect vulnerable people from abuse and from the risk of abuse. However, information about how to contact other agencies was not clear. The manager told us the procedure had been reviewed and would be made available and discussed with staff. Information about how to recognise or report abuse was not displayed for people living in the home and their visitors.

Records confirmed 22 out of 34 staff had received safeguarding vulnerable adults training. Additional safeguarding training was booked for October 2017. We discussed safeguarding procedures with staff and found their knowledge in this area varied. Most staff knew what to do if they witnessed or suspected any abuse and indicated they would have no hesitation in reporting any concerns either to the person in charge or to other agencies. Whilst one member of staff said they were not aware of how to report their concerns to external agencies and another said they would contact the local GP practice for the information. However, we noted the contact information for reporting safeguarding concerns was displayed in the staff office. We discussed the management team's responsibilities for reporting incidents and safeguarding concerns. We noted the management team were currently working in cooperation with other agencies.

People living in the home told us they generally felt safe in the home. They said, "I feel safe but not when there are so many agency staff on; they don't know me", "The staff are unhappy with things, they talk to us about the problems and we become involved. That makes me feel angry and not safe", "The staff are nice to people" and "The staff are okay towards me and to other people here." A visitor said, "I find everything to be fine. I feel [my family member] is safe here" "[My family member] is safe here but there is a lot that is not right at the moment." During the inspection we observed people were comfortable around staff and staff interaction with people was friendly.

At our last inspection, we recommended the service sought guidance about improving the recruitment and

selection process. During this inspection, we looked at four staff recruitment files. We found there had been limited progress made with this. We found not all the checks had been completed before staff began working for the service. For example a full history of employment, suitable references and a photograph as a means of identification had not always been obtained. Disclosure and Barring Service (DBS) checks had been obtained. However, one member of staff only had a standard rather than an enhanced DBS check in place; the manager took immediate action to resolve this. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

When agency staff were used, confirmation of their experience, qualifications and fitness to work in the home had not always been received. The manager contacted the agency for additional information following the inspection.

The provider had failed to follow safe and robust recruitment processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A health assessment, to determine whether a person was fit to undertake the role applied for, had been requested following the application which demonstrated a fair selection process. Regular checks on the registration status and fitness to practice of all nursing staff had been completed.

We looked at how people's medicines were managed. At the last inspection, we recommended the service sought appropriate guidance to develop policies and procedures which were reflective of the medicines system in use. During this inspection, we found the system of medicines had been changed last month. A monitored dosage system (MDS) of medicines was being used. This was a storage device designed to simplify the administration of medicines by placing the medicines in separate sleeves according to the time of day.

Nursing staff who were responsible for the safe management of people's medicines had received update training although checks on their practice had not been completed. The manager had started undertaking the assessments by the third day of our inspection. Policies and procedures were available for staff to refer to although they were not reflective of the current MDS system in use.

We looked at five Medication Administration Records (MAR). We found most directions were clear although one person's MAR stated 'as directed'. Any allergies people had were not recorded; this meant staff and health care professionals were not informed of any potential hazards of administering certain medicines to them. People were not identified by photograph on the MAR which increased the risk of error, particularly when agency nursing staff were being used.

We found appropriate codes for non-administration had not always been used and the reasons for omission had not been recorded. A nurse had amended the directions on one person's MAR; there was no information to support whether this had been agreed by a medical practitioner. Medicines that were prescribed 'as needed' were not supported by clear guidelines and handwritten entries were not always witnessed. Bottled medicines were routinely dated when opened although boxed medicines were not; this meant it was difficult to monitor whether the medicines had been given safely. The application of patch medicines (to be applied to the skin each day) were not being recorded appropriately.

Medicines for disposal were stored in a locked cupboard and in a tamper proof bin. However, we were unable to monitor the disposal practices as a new system had been introduced. Arrangements were in place for the management of controlled drugs which were medicines which may be at risk of misuse.

Controlled drugs were administered, stored and disposed of appropriately and recorded in a separate register. We checked one person's controlled drugs and found they corresponded accurately with the register. However, we noted one occasion that had not been witnessed in accordance with procedures. We found medicines that needed to be crushed prior to administration were not crushed with the recommended appliance.

The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were records to support 'carried forward' amounts from the previous month which helped to monitor whether medicines were being given properly. We observed people's medicines were given in the correct manner with encouragement as needed. However, the medicine round took the nurse most of the morning; this meant they were unavailable for other duties.

We looked at how the service managed risk. Environmental risk assessments and procedures to be followed in the event of emergencies were being developed. Individual risks had been identified in people's care plans and included skin integrity, nutrition, dependency and moving and handling. However, we found that risk assessment information had not been regularly updated and the severity of the risk had not been considered when determining the review frequency. For example one person's assessment indicated they were at high risk of developing pressure sores; the records had been reviewed in February 2017 and were not due to be reviewed until six months later. Another person's nutritional risk assessment had not been updated since 2016 despite needing specialised diet and fluids as recommended by the speech and language therapist. The manager assured us the care records were being reviewed and updated although slow progress was being made with this.

We noted people's personal allowances were being managed by the home. We saw clear documentation regarding this although there were no risk assessments in place to protect people. We checked two people's personal monies and found the balance was correct.

The provider had failed to ensure people were protected against the risks to their health, safety and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence to support incidents and accidents were being analysed by the manager each month. This helped to determine whether incidents were occurring at particular times of day or night and whether they were due to a lack of staff.

At our last inspection, we recommended the service sought advice about ensuring staff numbers were consistent and that sufficient numbers of staff were available at all times. Prior to this inspection, we were told there were not always sufficient staff available and the service was using a high number of agency staff. During this inspection, we noted eight members of staff had left for various reasons. This meant the service had to rely on agency staff until new permanent staff could be recruited.

We looked at the staffing rotas. We found there were sufficient numbers of staff available however the numbers of staff varied each day; this made it difficult to plan and provide consistent care and support. For example, some mornings there was one nurse and six care staff whilst other mornings there was one nurse and four care staff on duty. Staff told us it was difficult to meet people's needs properly when there were only two care staff on each floor of the home. The manager told us rota planning was difficult as a number of

staff had fixed hours and that this was being reviewed.

The rota showed the morning staff were also supported by a breakfast server who was available 8am – 11:30am. There was also a senior carer who was supernumerary and the housekeeper who was able to step in and assist as a carer if needed. Evening staffing was either four or five care staff with one nurse. A cook, laundry assistant and a domestic worked each day. A handyman was available two days each week; we were told a full time handyman was due to commence the following week and night care staff to commence this month (August 2017). We were told the service was recruiting nursing and care staff and an additional domestic staff. The provider told us an activities co-ordinator had been selected from within the staff team.

We found the rotas were not clear about who was working in what role which meant it was difficult to determine the number of staff available and working. The manager assured us this would be made clearer. We were told the numbers of staff had been adjusted when the occupancy levels had reduced and agency staff were covering nursing and care shifts. We noted the same agency staff were used where possible to create consistency of care for people.

People said, "Sometimes there are enough staff but not always", "I don't know why staff have left; it's not the same place that it was", "Staff keep leaving; who will go next, so many in a short time", "Staff have left and agency staff are being used. I don't know who they are and they don't know what I want or need. They don't know the routines. We used to be a family and it's not like that now", "The agency staff aren't good; they don't know me like the others do" and "They still come when I need them so I feel the staff levels are okay. They are very nice and kind to me." Relatives said, "They seem to be short staffed and very busy", "They are using agency staff; they don't know my relative" and "There have been so many staff changes."

Staff told us, "Staff are unhappy and have left; there has been a big turnover of staff", "The nurses do not have enough time to do anything other than medicines", "We don't have time for pampering or to sort out residents' clothes" and "The numbers of staff are not consistent; it makes it difficult to manage each shift. The staffing levels used to be very good here."

We saw equipment had been serviced. We found documentation was in place to demonstrate health and safety checks had been carried out on all aspects of the environment. For instance, water temperatures, emergency lighting and the fire systems. We also noted servicing certificates were available to demonstrate equipment had been serviced at regular intervals. We found the service file was not organised and we had to request additional documents; the requested certificates were provided on the third day of the inspection.

Training had been given to staff to deal with emergencies and to support them with the safe movement of people, fire safety and emergency first aid. Further first aid and moving and handling training was planned for designated staff in October 2017; designated staff would be able to provide ongoing support and training for other staff. During our visit we observed safe and appropriate moving and handling interactions; we noted all moving and handling slings had been replaced following a recent review. There were contingency procedures to be followed in the event of emergencies and failures of utility services and equipment. A business continuity plan was being developed to respond to any emergencies that might arise and would set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

The fire safety officer had visited the home in January 2017 and following a further visit was satisfied all recommendations had been actioned. We noted there had been a delay in addressing some of the recommendations such as the application of emergency door closures and the removal of an emergency exit sign. We also asked the maintenance person to check all foam door strips were in place as we found two

doors without them. People had a personal emergency evacuation plan, which set out the assistance they would need in the event of an urgent evacuation of the building. The manager and nursing staff were updating these to include more detail and the risks relating to the use of paraffin based creams were also being reviewed.

We found there was open entry to the home during daytime hours; we were told people would use the doorbell at other times. Visitors did not consistently sign in and out of the home as the sign in book was not easily located. We discussed security and safety without placing limitations on people's freedom and independence with the manager.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found the provider had failed to provide staff with appropriate support, training, professional development and supervision. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection, we found the provision of learning and development had improved. Much of the training had been provided as e-learning on the computer. However, the manager told us face to face training had been arranged for staff. From looking at records and from our discussions we found staff received a wide range of appropriate training to give them the necessary skills and knowledge. Training included fire safety and evacuation, safeguarding, end of life, moving and handling, first aid and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Additional training had been provided to support nursing staff with maintaining their registration with the Nursing and Midwifery Council (NMC).

We noted the training matrix had not been updated to reflect staff changes and there were a number of gaps in the provision of training. The manager was aware of this and staff had been registered on additional training sessions which included safeguarding, challenging behaviour, nutrition and health, infection control, medicines management, health and safety, end of life care and cleaning principles. Most care staff had completed a nationally recognised qualification in care or were currently working towards one; this was not clearly noted on the training matrix. There were systems in place to ensure training was completed in a timely way. Staff told us, "Training has improved; more has been implemented", "We get loads of training, too much" and "We are being asked to attend more training; it's hard to fit it all in."

Records showed new staff received a basic induction into the routines and practices of the home which included a period of time working with more experienced staff. The Care Certificate had not yet been introduced; the manager was aware of this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. One new member of staff told us their induction had been very useful for them.

Records showed staff had not received regular supervision. We were unable to find any assessments to check staff knowledge and competence in areas such as moving and handling and medicines management. The manager told us she had developed a plan for one to one support and competency assessments. Appraisals of staff work performance had not been undertaken; these would help identify any shortfalls in their practice and any additional training needs. Staff told us they felt supported by each other but not supported or valued by the management team.

Regular handover meetings, handover records and communication diaries were used to keep staff up to date about people's changing needs and the support they needed. Staff told us the handover process had improved. Staff spoken with had a good understanding of people's needs. A daily handover sheet was completed to keep the manager up to date with any changes in occupancy, staffing, care and support, incidents and accidents; however the copies we looked at were incomplete.

We looked around the home. At the last inspection, we noted areas of the home were in need of attention. However, at that time improvements had commenced and a formal development plan was in place to support ongoing improvements. During this inspection, we did not look in all the rooms but found the décor, furniture and fittings was tired and in need of updating; little progress had been made with improving the home. We noted damage to doors, plaster, wallpaper and woodwork. The hydro pool was not in use as the faulty pump had not been replaced. The conservatory was no longer used; the roof was leaking, the blinds and window closures were broken and the room was cluttered with old furniture and equipment.

People said, "The home is shabby with little evidence of investment" and "It needs more attention." The manager was aware of the shortfalls and we were assured a room by room audit would be undertaken to determine improvements needed.

The provider had failed to ensure the home was properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most bedrooms were single occupancy and some had en-suite facilities. People told us they were happy with their bedrooms and they had created a homely environment with personal effects. This helped to ensure and promote a sense of comfort and familiarity. People could have keys to their bedrooms. One person said, "I like my bedroom; it's a bit untidy but that's how I like it."

Maintenance staff were available and a system of reporting required repairs and maintenance was in place. We were told repairs were completed promptly. Following the inspection we were told removal of broken furniture and equipment was underway. An additional handyman commenced following our inspection.

By the third day of our inspection we found a room by room audit had been undertaken. Areas for improvement had been identified.

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 make 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were policies and procedures to support staff with the MCA and DoLS which were being reviewed. Records showed 29 out of 34 staff had received training in this subject. The manager and staff expressed an understanding of the processes relating to MCA and DoLS. However, two staff told us they were unsure about the MCA.

At the time of the inspection two DoLS applications had been made to the appropriate agency. However the reasons for the authorisation had not been clearly documented in the care plan. This meant people's best interests or choices may not be considered. Nurses were aware of who was subject to a DoLS and this information was included on the handover sheet.

We observed staff asking people for their consent when providing care and treatment, for example when administering medicines or supporting people with meals or with moving from one part of the home to another. However, consent in relation to areas such as information sharing, taking photographs and gender

preferences around support with personal care needed to be recorded in the care plans. The manager assured us this would improve with the introduction of the new care plan system.

The service did not yet have a policy in place with regards to resuscitation (DNACPR - do not attempt cardiopulmonary resuscitation). New policies were being introduced. We looked at records relating to DNACPR decisions and found they did not clearly show that decisions had been discussed with people. People's wishes in respect of DNACPR were not clearly documented to ensure their wishes would be upheld or to ensure appropriate action was taken in the case of a medical emergency. The manager assured us this would be recorded in the new records.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals. They told us, "We get home cooked food and choices. If I don't like something they will do me a baked potato", "The meals are alright", "I always get enough to eat" and "I can have what I like; I enjoy the meals. They asked us what we would like on the menu."

During our visit we observed lunch being served. Most people sat in the main dining room although people told us they could dine in other areas if they preferred. The meals looked appetising and hot and the portions varied in amount for each person. Staff were attentive to people's needs although on the first day of our inspection we noted people were waiting some time for assistance. We saw people being supported and encouraged to eat their meals and were given the time they needed to eat their meal.

The manager was aware that the records needed to include more information about people's dietary preferences and any risks associated with their nutritional needs. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed. However we found staff were unaware of changes to people's nutritional needs. We have dealt with this separately in the report.

We looked at how people were supported with their health. People told us they could see a doctor if they needed to. We saw evidence of referrals to a variety of health care agencies including GPs, dieticians, speech and language therapy services and podiatry services. Healthcare appointments and visits were documented in people's care records. During the inspection we observed one person attending a local health care appointment with a member of staff.

Good

Is the service caring?

Our findings

People told us, "The staff are wonderful", "The care is good and always has been" and "The care is not as good; how can it be when agency staff don't know people." Staff told us, "We love the residents they are like family."

People confirmed there were no restrictions placed on visiting; visitors told us they were made to feel welcome. We observed good relationships between staff and people living in the home. People who required support received this in a timely way. People appeared comfortable in the company of staff and it was clear they had developed good relationships with them.

We looked at how people's privacy and dignity was respected. We saw people were dressed appropriately in suitable clothing of their choice. A relative told us people's clothes were not cared for. They said, "Clothes are not put away, they are left in the bedroom; it is untidy." Each person had their own bedroom which was comfortably furnished with their own belongings. People told us they could spend time alone if they wished and that staff knocked on doors and waited for permission to enter. We noted that people nursed in their bedrooms were comfortable and staff regularly checked on their welfare taking time to chat with them.

There were policies and procedures for staff about caring for people in a dignified way and all staff were bound by contractual arrangements to respect people's confidentiality. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. People told us staff treated them with dignity and respect. Staff spoke about people and to them in a respectful and manner. However, we found confidential personal care and support information displayed on the dining room notice board and personal care records were stored in an unlocked room. This was not respectful of people's rights to confidentiality, dignity and privacy. The manager addressed the issues during the inspection.

Where possible, people were able to make their own choices and were involved in decisions about their day for instance how they wished to spend their time and what they wanted to eat. People told us, "I can come and go as I please", "Staff know my routines and work around that" and "If I go out I let them know." People told us they determined their own day and there were no rigid routines imposed on them that they were expected to follow.

People were encouraged to express their views by means of daily conversations with staff and with the provider and by completing annual customer satisfaction surveys. People confirmed a recent relatives meeting had been held but was poorly attended; we were unable to locate any minutes to determine what had been discussed. We found there had been informal discussions with people about where they would like to holiday and about any external activities they wished to attend.

People told us staff kept them up to date with any changes during daily conversations. However we found this had impacted in a negative way. People were worried about how the changes would affect them and they were worried that the home would be closed. They said, "I wish they would stop bickering and get on

with it. It's our home, and it affects us. We just want to be told what is going on."

People did not have access to information (service user guide) about the standards of service they should expect. The manager was aware this needed to be updated and shared with people. In addition we noted the St Andrews House web site was factually incorrect and misleading in terms of the facilities available. We discussed this with the provider and manager and were given assurances this would be reviewed. Information about the advocacy service was displayed in the entrance. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

Requires Improvement

Is the service responsive?

Our findings

People were complimentary about the staff. People told us they knew who to speak to if they had any concerns or complaints and could raise any concerns with the staff; this was confirmed in a recent customer satisfaction survey. People said, "I have been unhappy with some things but have just got on with them", "I am looked after but when agency staff are on I get left sometimes", "The managers don't listen", "It was very homely. Staff have been here years; that is until recently" and "I would tell the staff if I was unhappy with anything." A visitor said, "I know how to make a complaint but I don't want to make things worse."

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) but not other external organisations such as the commissioners and the local ombudsman. The manager told us a new policy would be shared with staff and people using the service. We noted the complaints procedure was not easily accessible for people living in the home and their relatives.

There had been two complaints made directly to CQC about this service in the last 12 months regarding staffing levels, availability of equipment, management of the home and care. There had been four complaints made directly to the home regarding staff attitude, care and support and cleanliness. Records showed appropriate and timely action had been taken to respond to the complaints; two complaints were still being investigated by the service. We noted people's concerns were not always recorded. Records were needed to determine whether there were recurring problems and to show whether appropriate action had been taken and whether the information had been monitored and used to improve the service.

Before a person moved into the home a detailed assessment of their needs was undertaken. Information was gathered from various sources about all aspects of the person's needs. Most people were able to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff were able to determine whether the home was able to meet their needs.

We looked at the arrangements in place to plan and deliver people's care. Prior to the inspection we were told the care plans and associated records were not up to date. At the last inspection we found some of the information was out of date and we were provided with an action plan that indicated the care plan documentation would be implemented by May 2017. We found there had been limited progress made with this.

We found each person had an individual care plan which was underpinned by a series of risk assessments. We found information was not clearly recorded about people's likes, dislikes, preferences and routines which would make it difficult to ensure they received personalised care and support in a way they both wanted and needed. We found the information was not always reflective of the care being given which meant there was a lack of clear instruction for staff, including agency staff, which could result in care not being provided as needed.

For example one person was nutritionally at risk and at very high risk of developing pressure sores yet there was not information to indicate how the person would be supported or of any action taken to reduce the risks. Another person's record indicated 'may hit out at staff' but there was no information to guide staff to manage this situation safely. One person had been provided with new dentures but this was not referred to in the care plan regarding how it may impact on their dietary intake and another person's catheter care was not recorded. It was difficult to determine whether one person needed pureed meals or pre mashed meals and whether fluids needed to be thickened or not.

We discussed this with the manager who acknowledged the care plan documentation required further development. From our discussions and from looking at records we found meetings with the nursing staff had taken place to ensure improvements to the care plans were made as a matter of urgency; however there was slow progress with this. By the final day of our inspection we were told one person's care plan had been developed. We noted only nursing staff were responsible for the development, review and updating of people's records. We were concerned that the lack of information in people's care plans was not in line with the NMC guidance on record keeping.

The information in the care plans had not been kept up to date or reviewed in line with changing needs. We found reviews had not been undertaken since 2016 and some records had not been reviewed since 2015. People had not been involved in the review of their care. Visitors said, "I'm not kept up to date with [my family member's] condition", "I'm kept up to date and I know about the care plan" and "I've not seen the care plan in a while; probably about 12 months ago." One person said, "I know about the care plan but I've not seen it recently; staff know what I need and get on with it."

Daily records were maintained of how each person had spent their day and these were written in a respectful way. However nursing staff had recorded 'care as per plan'; it was difficult to determine what this meant as the care plans were not up to date. One member of staff said, "Carers tell the nurses what they have done and the nurses write up the notes three times a day." This meant the nursing staff were responsible for recording care and support that they had not provided. This could result in inaccurate information being recorded. We discussed this with the manager.

The provider had failed to have suitable arrangements in place for planning people's care and support, in a way that met their individual needs and preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people were admitted to hospital they were accompanied by a record containing a summary of their essential details, information about their medicines and a member of staff or a family member. In this way people's needs were known and taken into account when moving between services.

At the time of our inspection the service did not have a dedicated activities person which meant the provision of activities was reliant on when care staff were available. There were limited records of any activities that had taken place. One person said, "No activities. I'm going stupid. I read books and amuse myself. I'm bored." Staff said, "There are occasional activities but if we are short staffed we have to do care instead" and "I think the residents are bored and sad that we don't have any activities." However, whilst activities within the home could be improved, people also told us about the recent canal boat trips, visits to the local tea shop, the theatre, the leisure centre, Emmerdale and the outlet shopping mill. They also told us about the holidays to Spain, Southport and Blackpool that they had enjoyed or had planned for this year. Relatives said, "[My family member] often helps out at the home and enjoys going on errands to the town", "They've been on a cruise on a specially adapted canal boat recently. I'm going with [family member] on the next one. It's good we can spend time together" and "[My family member] is looking forward to going to a

concert."

Some people were independent of staff and would go shopping, out for a meal or a drink, meet with friends and attend their GP surgery or clinics; other people relied on staff to accompany them. We observed some people sitting outside with a drink, chatting to staff, their visitors or each other. Following the inspection we were told an activities coordinator had been recruited.

The service had good links with the local community such as local shops, cafes, pubs and charitable and fund raising organisations. We were told, "It's a friendly town, and everyone knows everyone. [My family member] often goes out into town and people always wave and say hello" and "People from the home get involved with 'Barnoldswick in Bloom' and with helping to sell poppies. It's a nice, friendly community."

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had failed to operate effective quality assurance and auditing systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a number of shortfalls during the inspection had not been recognised or recorded. The provider sent us an action plan and advised audit systems would be in place and operating from August 2016.

During this inspection we found systems were in place to monitor health and safety, environment, training, dignity, human resources, medicine management and catering. The manager had completed the required quarterly reports for the health commissioners which included an overview of falls, pressure sores, DoLS and infection rates in the home. During our inspection we found shortfalls in medicines management, recruitment, care planning and risk assessment. We found the provider, manager and clinical service manager were aware of the shortfalls and action was being taken to address the issues. We were shown new systems that had been introduced although we noted slow progress had been made with any improvements. For example, we received an action plan in January 2017 advising care records would be reviewed and in place by May 2017. This meant the quality assurance systems had not been fully effective.

People told us the nominated individual (owner) regularly visited the home and spoke with people in the home, their visitors and with staff. We looked at the reports of her findings but found they had not been shared with the manager. This meant the manager was unaware of any action needed. People said, "I speak with [the nominated individual] she comes over and has a natter" and "I am always able to speak with [the nominated individual]; she is a lovely person."

People were asked to complete annual customer satisfaction surveys to help monitor their satisfaction with the service in areas such as complaints, staffing, satisfaction, involvement and meals. The last survey had been completed by nine people in April 2017 and overall the results were positive. However, the results had not yet been analysed or shared with people. We were told there had been a relative's meeting held although the date was unclear and the minutes were unavailable. A relative said, "The meeting was not well attended as only two of us turned up." There were no meetings held for people living in the home. People said, "There are no meetings. We just want to be told what is going on." The systems to seek people's views and opinions about the running of the home needed to be improved particularly in light of people's unsettlement.

The provider had failed to operate effective quality assurance and auditing systems. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been a registered manager in post since July 2016. The manager and the provider were aware an application to register the manager needed to be forwarded to the commission. There had been a manager in post for a short period of time in January 2017. The current manager had been in post since May 2017 and was not yet registered with the commission. The manager was supported by a clinical service manager who had been in post since January 2017 and who was responsible for setting up new systems.

From our discussions and from the records we looked at it was clear the relationship and communication between the management team and a number of the staff was difficult. This was impacting on the day to day management of the service, the ability to improve the service and on people living in the home. In addition we were told the manager was not a visible presence in the home. Some people told us they were unclear who was in charge and who they could approach with their concerns.

We found there was a lot of unsettlement and anxiety for people using the service and for their families; we found the atmosphere was not as happy and settled as at previous inspection visits. People said "This is my home and I have lived here for so many years. I am fed up and upset with it all. They [staff and managers] need to stop bickering and get on with making it right" and "Where is it all going to end." Relatives told us, "I've not met the new manager", "It's not been good for a while", "I've met the manager she is very nice" and "I've not met the manager yet, I've not been introduced. I'm unsure who is in charge."

During our inspection we found the staff team were unhappy and unsettled. They said they were not kept up to date. Staff comments varied and included, "There is no leadership" and "If things were discussed and reasons given it would be easier." They also said, "I have no problem with the managers", "I do like it here; I love the residents" and "We want things to change for the better." Staff had access to a range of new policies and procedures to support them in their work. The manager told us they would be shared with and discussed with staff. Some staff had not been provided with contracts of employment or job descriptions. This meant they may not understand their contractual responsibilities or the responsibilities of their role.

Staff meetings had been held although not all minutes from the meetings were available. We were told meetings with the nursing staff had been held in February and April 2017. A recent agenda for a meeting held August 2017showed areas for discussion included infection control, poor practice, confidentiality, employment issues and the recent safeguarding alert. We saw minutes from a general staff meeting held in February 2017 which included discussions about safety, cleanliness, staffing and activities. The manager was aware of the need to share the outcome and any actions needed from the meetings with staff.

We found records relating to the management of the regulated activity were not always accurate or stored securely. We have dealt with this separately in the report.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local commissioners, local authority safeguarding and deprivation of liberty teams.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to have suitable arrangements in place for planning people's care and support, in a way that met their individual needs and preferences. Regulation 9 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The provider had failed to ensure the home was properly maintained. Regulation 15 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider had failed to follow safe and robust recruitment processes. Regulation 19 (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people were protected against the risks associated with poor infection control. Regulation 12 (2) (h) The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12 (2) (g) The provider had failed to ensure people were protected against the risks to their health, safety and wellbeing. Regulation 12 (2) (a)

The enforcement action we took:

We sent out a warning notice against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective quality assurance and auditing systems. Regulation 17 (2) (a) (b)

The enforcement action we took:

We sent a warning notice against the provider