P.A.R. Nursing Homes Limited

Atherton Lodge

Inspection report

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13 December 2016

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an inspection on 12 and 13 December 2016. The first day was unannounced.

Atherton Lodge is a privately owned two-storey detached property that has been converted and extended into a care home. It is registered with Care Quality Commission (CQC) to provide accommodation for up to 40 older people who require personal and nursing care. Some people at the service were living with dementia. Following the last inspection, the registered provider took the decision to cease providing nursing care. In conjunction with staff from the local authority and the Clinical Commissioning Group, those people deemed to require this level of support were found alternative accommodation. At the time of the inspection there were 23 people living at the service who required accommodation and personal care only.

There was no registered manager in place and there had not been one since February 2015. 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. There was a manager in post who started in August 2016 and whom had submitted her application to CQC for registration.

At the last inspection in August 2016 we found that a number of improvements were needed in relation to, meeting nutritional people's needs, planning people's care and support, the environment, identifying people's health needs and monitoring the quality and safety of the service. We found the service in breach of Regulation 12 and 17 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.

This inspection took place to establish what improvements had been made and whether the registered provider now met legal requirements. We found that there were on-going concerns and breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not kept safe from the risk of harm. Not all of the risks to people were assessed, reviewed or managed. This included the physical, medical, emotional and mental needs of people who used the service. Accidents and incidents were recorded but there was not always evidence of a follow up to ensure people's safety or to improve their care.

The registered provider had introduced a dependency assessment in order to demonstrate that they had the right number of skilled and experienced staff to meet the needs of the people who used the service. Out of the seven assessments reviewed three were incorrect and one had not been reviewed since September 2017. If assessments are not accurate there is a risk that staffing levels may not be adjusted accordingly.

There was a new chef in place who was carrying out a review of menus to ensure that people had a greater

choice of meals and drinks. The chef had received advice and guidance from the dietetic service. People were observed to have a poor dining experience. Staff gave people the option to sit at the dining tables but this was not well organised and some people sat and waited for 50 minutes for their meal. During this time they became unsettled and uncomfortable. Tables were not laid with cloths, place mats or condiments. Menus were not available to help people make a choice or identify their meals and the menu board was not easy to locate or read.

The Statement of Purpose stated that the service can provide support to people living with dementia and also people with sensory impairment. We found that the accommodation, adaptations, stimulation and specialised support was not in place to support people with these conditions. This meant that staff could not meet people's needs in an effective way and the environment did not meet their needs.

Staff had received training in the Mental Capacity Act 2005 (MCA) and were able to discuss this with us. However, care plans failed to address a person's ability to make decisions about care and support or evidence where decisions had been made in a person's best interest. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some people who used the service were subject to a DoLS but the registered provider had not taken account of the conditions imposed within the DoLS authorisations.

People felt that the staff were caring and supportive and they expressed affection for them. Observations showed that some staff did not know how to support people who were distressed or may be seen to challenge others. We observed that some distressed behaviours were seen as 'normal interactions' and staff did not always manage or support people appropriately.

Staff were able to tell us about a person's support needs and their likes/ dislikes. Some records indicated what was required of staff in order to provide. However this was not consistent those records lacked detail and did not reflect people's current needs especially around the monitoring of health conditions. This meant that people may not receive the care and support that was required to keep them safe.

Furniture, fixtures and fittings were in need of replacement or repair. There was a lack of cleanliness throughout the service and a malodour was present in some areas of the building. There were risks to a person's safety as aspects of the building were deemed to be unsafe. Other concerns were identified in regards to infection control and increased risks to a person of acquiring an infection.

The complaints log was located and two formal complaints had been logged. The manager informed us that no other complaints had been made about the service. A response had been provided in each case but there was no evidence of how the complaints had been investigated in order to reach the identified outcome.

People and their families had been provided with the opportunity to express their views about the service though meetings and discussions with the registered provider. There were mixed opinions shared as to the confidence people had in the registered provider to remedy all concerns.

Whilst some improvements have been made to the registered provider's governance and auditing systems these were still not robust to ensure the safety of people was maintained. The registered provider had failed to ensure that the home had improved or sustained improvement in some identified areas. The registered provider had enlisted the services of an external consultant to better monitor the safety and welfare of people who used the service.The inspectors found no written action plans to evidence what remedial steps had been agreed and taken following these visits. The registered provider informed us that verbal actions

had been agreed at the end of each visit. However, we found that some of the issues highlighted had not been resolved. This meant that there were inadequate processes in place to assess and monitor the quality and safety of the service.

Staff had confidence in the manager and said that it was good that she was trying to bring a consistency to systems, structures and record keeping requirements. The registered provider told us that he now had a better understanding of the requirements set out in the Health and Social Care Act 2008 and his responsibility within this. There was also evidence that he had a more regular presence within the home.

CQC were notified of key events which adversely affected people's safety and welfare. There was, however, a failure to notify the CQC of those persons subject to a DoLS.

The management of medicines had improved which meant that people would get the medicines that they required. Improvements had been made to ensure that medication was stored safely and in line with manufacturer's instructions. Records in regards to medicines were accurate and there were care plans which provided staff with information to ensure that the right medication was given to the right person at the right time.

Staff training had been updated and staff told us that they now felt better able to carry out their role. Staff had received supervision and felt able to go to the manager or one of the senior staff if they had any concern. This meant that people were supported by staff that had improved skills and knowledge to carry out their roles effectively.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

The service 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.

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.

The premises were not clean or safe and therefore people were at risk of harm or acquired infection.

Risk assessments were in place to help staff identify and manage risk. However, these were not adequate. They failed to highlight all of the issues in order to help staff to keep people safe.

Improvements had been made to ensure a more robust management of medicines. People received their medication as prescribed.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Assessments did not demonstrate that staff had assessed a person's capacity to make a decisions or whether they were acting in their best interests.

Staff had received training and supervision to enable them to develop further skills and knowledge.

People were supported to have food and fluids although not all liked what was on the menu.

Is the service caring?

Inadequate

The service was not consistently caring.

People said they felt cared for and some staff were observed to be patient and kind. Relatives were pleased that some of the staff had stayed despite the poor CQC report.

However, some aspects of support impacted on a person's dignity and did not afford them respect.

Is the service responsive?

Inadequate

The service was not fully responsive.

Care plans were not consistent and so there was a risk of a person not receiving person centred care. Daily records were inconsistent and did not evidence what care had been provided or offered.

Complaints were responded to but there was not a clear audit trial to demonstrate how outcomes had been reached.

Planned activities were now on offer two days a week and people loved the opportunity to participate.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had introduced an audit system and the help of an external consultant. However, audits were not checked for accuracy and were not robust. They failed to highlight concerns we raised during this inspection.

The registered provider was taking a more active role in the service and had attended meetings with people who used the service, family and staff.

There was a manager who had applied to the CQC for registration.

Atherton Lodge

Detailed findings

Background to this inspection

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

The inspection took place on the 12 and 13 December 2016 and the first day of the inspection was unannounced.

The membership of the inspection team comprised of two adult social care inspectors and a pharmacist inspector.

Prior to the inspection we looked at the notifications we had received from the registered provider as well as any notifications from other professionals or members of the public.

We talked to six people using the service, eight relatives and friends or other visitors such as one two health and social care professionals. We also carried out some pathway tracking of ten individuals which included speaking about their support and reviewing their records. We carried out observations in the communal areas throughout the day.

We spoke to six staff throughout the course of the inspection as well as the manager and the registered provider. We looked at staff training records, supervision schedules and other information pertinent to staff support.

We reviewed other information of relevance to the running of the home and this included maintenance records and quality audits.

We contacted the local authority who had been meeting with the registered provider on a weekly basis following the outcome of the last inspection. They shared with us their thoughts and opinions as to how the service was progressing and where continued or sustained improvement was required. We also spoke with the Infection Prevention and Control Team, the Fire Service and Speech and Language Therapists.

Inadequate

Is the service safe?

Our findings

People told us that it was "Calmer" and "Different" now that a number of people had moved from the service. One person said that "There is a change for the better as there are less people". Relatives also commented that improvements had been made and things were "Safer".

The last inspection highlighted that the premises required remedial action to ensure it was clean, safe and well maintained. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we deemed that sufficient improvements had not been made to ensure that the premises were safe and clean.

Relatives we spoke with had no concerns about the cleanliness of the building and highlighted that some parts had been painted. Although staff were employed to carry out domestic duties, we found areas of the home to be dirty. Cleaning methods were not sufficient to ensure that rooms were cleaned to the required standard or had a deep clean. For example, we found dirt/ debris in a sink and dirty spoons in a room where cleaning had taken place. One shower room had dried faeces on a handrail and the shower chair and shower curtain were dirty. Skirting boards were dusty, pull cords dirty, and there were marks and stains on walls and ceilings. Fans and vents throughout the building had not been cleaned.

Some areas of the home remained a risk in regards to infection control as they required remedial repairs and so could not be kept clean: For example, there were holes in walls, flooring required replacing, handrails were damaged, chairs and cushions needed replacing, commodes were dirty/ rusting as were radiators that were exposed. Not all bins were pedal operated increasing the risk of cross infection. We also found unmarked toiletries for communal use. Some equipment was not clean and posed a significant infection risk. For example, a stand and night bag for the use with a catheter was found to be unclean on both days of our visit and stagnant urine was still evident in the connecting tubes. This posed a significant risk of infection to anyone using it.

The home was at risk of harbouring bacteria due to the poor management of infection control. This is in direct contravention of the guidance from the Department of Health Code of practice on the prevention and control of infections.

Some of the paper hand towel dispensers were too high and therefore some people would not be able to access them.The registered provider assured us that these were in the process of being moved. Hand Sanitizers were in corridors with no assessment completed as to their risk of ingestion for people with cognitive impairment. Whilst call bells were provided, some were not accessible to people deemed as requiring them: we found some to be out of reach, behind or down the sides of the bed and one had been unplugged at the wall.

Equipment was not stored appropriately; an example of this was a bathroom that was full of wheelchairs, shower chairs and mobility aids. Another room was full from the floor to ceiling of discarded items such as mobility aids, electrical items, Christmas decorations, cardboard boxes, mattresses and furniture. This room

was not locked was an identifiable safety hazard as accessible by people who lived at the home. Continence aids were stored on the backs of toilets and found on the floors of people's bathrooms.

Some rooms on the upper floor did not have window restrictors fitted to prevent people from climbing through them and falling from height. Covers had been removed off some radiators but there were no risk management plans put in place to ensure that these did not pose a risk in the interim period of time. The registered provider said they had been taken off as they required adaptation to allow the flow of heat. This meant that there was a risk that people could be burned by exposure to the hot surface.

Following the last inspection, the fire service undertook an audit of the service and issued the registered provider with an enforcement notice.The Registered Provider had until the 20th January 2017 to comply with the notice. A number of physical improvements had been made to make the building safer and staff had undertaken fire marshal training. At the time of the audit on the 7 October 2016, no evidence could be provided to demonstrate that the suitability of the evacuation strategy or the ability of staff to evacuate different areas of the building effectively. On inspection, the registered provider could still not demonstrate the suitability of the overall evacuation strategy. Following the inspection concerns were raised that the registered provider had reduced night time staffing levels. These concerns were shared with the Fire Service and it was concluded that no consideration had been taken at the time of the reduction as to the implications of this on the evacuation strategy. Timed /simulated evacuations had not taken place to test out the plan. These have subsequently taken place at the instruction of the Fire Service.

The required checks were being carried out on the utility systems, including gas, electricity and water. Staff told us they checked, but did keep a log, to evidence the temperature of the water prior a person having a bath or shower.

These remain a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that they had assessed the risk of and preventing, detecting and controlling the spread of infection. They had also failed to ensure that the premised were safe.

During this inspection we noted that some improvements had been made to individual risk assessments and management plans. However this was not consistent. Risk assessments were in place for some people, but not all circumstances, where there was an identified risk to health or safety.

People were able to leave the home but for some this had associated risks. For example: not returning in order to receive medication. Risk assessments were not sufficient to guide staff as to what actions to take in these circumstances. For example: one record indicated that staff were to make contact with the person on their mobile phone but there was no information or guidance in place for staff as to what to do or who to inform should contact not be made or the person refused to come back.

People may have physical or mental health conditions that require staff to be vigilant and proactive in their management. For example: One person had a specific infection which could have a negative effect on a person's health and others if they contracted it. This condition was not recorded in the care plan. There was no information as to how to minimise the risk of cross infection or how this could impact on their future care and treatment should they become unwell.

We spoke to the manager who was not able to confirm how many people used bedrails at the home but told us that some people did use them but that risk assessments had not been completed. There should be a risk assessment that covers the specific areas highlighted in line with the Medicines and Healthcare Products

Regulatory Agency (MRHA) guidance on safe use of bed rails. Individual assessments should be in place and personalised to identify the risk that the use of bed rails presents to each person. This meant that there was a risk of people receiving unsafe care and support that was not suited to meet their needs. For example accident records indicated that one person had trapped their hand between the bedrail and mattress and another had fallen trying to climb to the bottom of the bed to avoid the rail.

Relatives had a mixed view on the supervision of people whilst in the lounge areas. Some felt it had improved whilst others commented that staff were "Not always about". Some risk management plans were not achievable unless people were under constant supervision. Statements such as 'staff to be in the lounge at all times so that staff are there to help' or 'staff to be aware of [name] whereabouts at all times' were recorded. The lounge areas were observed to be left unsupervised for up to fifteen minutes periods. Inspectors witnessed a number of people being verbally abusive towards each other, swearing and having heated arguments. No staff were available in the lounge area and no one was there to intervene or diffuse the situation.

These remain a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not ensured that the risks to the health and safety of people were assessed and control measures were not in place to make sure that risks were as low as practically possible.

Staff had an understanding of Safeguarding and what this meant in their day to day work, what they needed to report and how. The manager had reported incidents of concern to the local authority in line with local protocol and had also notified the CQC of safeguarding matters. However, we found that not all incidents had been followed through where there had been a concern and a provider led investigation. A person had an unexplained injury and records indicated that statements were to be taken from staff to establish whether this was a safeguarding concern. There was no further information recorded or available and the matter had not been followed through. The manager was not able to inform us what the outcome of this had been.

Since the last inspection, a new accident and incident reporting process had been put into place. Staff were aware of this and followed the registered provider's policy. There was an analysis of individual occurrences and also a monthly evaluation of wider themes and trends within the service. However, this did not always highlight all patterns of concern in order for remedial action to be considered.

We previously visited this home in August 2016 and found them to be in breach of Regulation 12(2) (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found that improvements had been made.

Following the last inspection, the registered provider informed us that staffing levels would be determined by completing monthly dependency rating for each person. This was now in place but the dependency scores were not always accurate or up to date. This meant that the registered provider could not be assured that staffing levels were adjusted accord to need. We have requested that the registered provider continue to provide us with information in regards to the determination of staffing levels.

Medicine audits had been completed by the manager and by an external consultant and actions to be taken were clearly recorded and dates documented.

At this inspection, we checked the medicines and records for five people. We spoke with the registered provider, manager and a senior carer with responsibility for medicines on that day. Allergies were now

recorded on medicines records. Each person had a photograph and this reduced the risk of medicines being given to the wrong person. This is an improvement since our last inspection.

n the day of our inspection we checked the medicines room and found it to be locked when not in use. All of the medicines were now stored in a medicines cupboard to remove them from direct sunlight and the room temperature was being monitored with no current concerns. The medicines room was clean and organised, and the amount of medicines in stock was not excessive. The fridge temperature was recorded each day; however, the thermometer was not being re-set each day by staff, which meant the recorded temperatures might not have been an accurate record.

There were previous concerns about when "as required" (PRN) medicines should be given and a lack of information for medicines required at a set frequency. During this inspection all of these concerns had been managed. Medicines were not left out and people were observed to take them.

We found that some creams were stored in peoples own bedrooms. The manager informed us this was because they were required at the point of care delivery or some people used these independently. There were no assessments carried out to ensure that people were able to manage these correctly. Furthermore, no consideration given to the potential risks of others access to these medicines whilst they were not stored securely. Some medication in given by way of a patch that adheres to the skin: it is important that the position of these is rotated to ensure correct absorption. We found that one person had their patch applied in the same place on two consecutive change cycles which meant that there was a risk that the absorption was not as required.

We checked recruitment at the last inspection and found no issues: therefore we have not checked this on this occasion.

Requires Improvement

Is the service effective?

Our findings

People said that staff looked after them and ensured that they had what they needed. Families felt that staff managed most situations well and that improvements had been made to the catering arrangements.

At the last inspection, we identified that improvements were required in relation to the procedures, documentation and recording systems in order to ensure that the Mental Capacity Act 2005 (MCA) was fully implemented.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure 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.

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. Capacity assessments were not in place. There were no 'decision specific' mental capacity assessments in regards to interventions such as the use of restrictive equipment such as bedrails, lap tables, or covert medication.

The manager had identified that a number of people were being restricted or deprived of their liberty in the way their support was required. Applications had been submitted to the supervisory body in order for an assessment to be carried out and these aspects of support formally agreed as being in the person's best interest. However, prior to this application being made, there was no mental capacity assessment undertaken to determine whether the person lacked in the mental capacity to agree to their care being provided in this way. There was no evidence of other least restrictive options being considered and no best interest decision being concluded.

Some people had their DoLS approved by the supervisory body and "conditions" had been specified which the service must comply with. Neither staff nor the manager were aware of these conditions which were contained within the authorisation and these had not been highlighted within any care planning.

We saw aspects of restrictive practice. At 10.15 am on the first day of the inspection all nine people who sat in the lounge area had a lap table placed in front of them. Staff removed a Zimmer from in front of a person and placed it across the room out of their reach. There was nothing contained within individual care plans about the use of lap tables and whether this was a personal choice.

People received support with their medication and had a care plan to indicate the level and type of support required. However, there was no consideration of a person's mental capacity to agree to this and no consideration of whether this level of support was required in their best interest decision.

Care planning documentation used by the service required the person or their representative to sign and agree to the support being provided. We found that not everyone had done this and for other's another person had signed on their behalf. Where this had occurred there was no indication as to who this person was or whether they had the legal authority to consent on behalf of the person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that care and treatment was provided in line with the requirements of the MCA and DoLS.

Some people had a Do Not Attempt Cardiac Pulmonary Resuscitation order in place (DNACPR). The external consultant had noted that there was not always evidence that the medical practitioner had discussed the issue with the person or evidenced where they lacked capacity to make an informed decision (Tracy vs. Cambridge Hospitals). We corroborated this view through an examination of the care records. Staff were not aware that these DNACPR could be challenged and were not confident in identifying decisions that could possibly not be lawful.

The registered provider identified Atherton Lodge as being able to care for people living with dementia. On previous inspections, we advised them to consider best practice guidelines and to ensure that the environment was dementia friendly. The manager informed us that an 'expert' had been to visit the home but no changes had been made to date.

There was no evidence of any items of interaction or stimulus in the environment which could be used to support reminiscence and way finding such as memory boxes, pictures of the local areas and favourite pastimes of people supported. There were no items of familiarity in place to support people living with dementia to understand what a room, cupboard or space was used for. An example of this may be where pictures of food and drink in the environment are used to help people to identify the dining area.

Bedrooms doors displayed photos of a person in the present day, whilst some people living with dementia would not recognise themselves in this way. Not all places had contrasting handrails, toilet seats, or door frames to assist with perception of space.

Lighting across the home was varied. One corridor had daylight lighting in place, but other corridors and bedrooms were dimly lit casting shadows and dark areas. Different coloured flooring which could be perceived as steps or holes was found across the service which could create difficulties for people with visual perception issues. No consideration had been given by the registered provider as to whether this had contributed in any of the falls people had sustained.

Some of the day to day items such as the TV and or clocks were set high up on the walls so that they were not easily recognisable at eye level. The dining room notice board had been replaced with a white board but was not easily identifiable and the writing was in a pale colour that the inspectors even struggled to read. This meant that people were at risk of increased confusion and distress and their independence being limited as the environment did not specifically cater for their diagnosis.

This was a breach of Regulation 15 of the Health and social care Act (regulated Activities) 2014 as the environment was not well designed and did not offer suitable adaptations to support the needs of people

living with dementia.
We raised concerns during previous inspections regarding the mealtime experience of people and maintaining good nutrition and hydration. On the first day of the inspection there was an option of homemade quiche or sausages. We observed neither to go down well. Some people struggled with the skin on the sausage whilst others commented on the products being "Cheap and nasty" and "Not of good quality". People also were quite vocal in their dislike of the quiche with many plates going back with little of it eaten. On the second day, people seemed to better enjoy the traditional stew. A new chef had been in post since the last inspection and all foods were now cooked from fresh ingredients. They were able to discuss with us changes they had made or planned to make to meal times. Some new foods were being introduced and greeted with mixed opinions. The chef recognised this but were adapting the menu and trying new foods with the aim of increasing the choices available.

We observed at lunch time that one person did not want to eat what was on the menu. Staff offered an alternative of a sandwich and the person accepted. When we reviewed the person's records, there was a recommendation made in November 2016 by the speech and language team (SALT) that they should not eat bread and should be provided with a soft diet. Food charts indicated that unsuitable foods had been offered and accepted on a number of occasions. Staff on duty told us that this had been reviewed and the recommendation was no longer applicable. We contacted the SALT team following the inspection who confirmed that the original recommendation was still in place and letting the person have bread (or similar textured foods) placed them at a significant risk of choking.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because care and support was not provided in a safe way.

The last inspection had highlighted concerns that the registered provider had failed to ensure that staff providing care and treatment had the required support, competence, skill and experience to do so safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We found that some improvements had been made.

Staff told us that they felt better supported and that they had received the opportunity to have a one to one with a senior member of staff. Records indicated that staff had received a supervision session in October 2016. The manager informed us that this would be carried out on a regular basis but the next sessions were yet to be planned.

Staff had been provided with updates/ refresher training in a number of areas such as safeguarding, moving and handling and mental capacity. Additional training had also been carried out to ensure that staff developed new skills in medicines administration, dementia and challenging behaviour. Staff confirmed that they had found this training informative and they had adapted their approach towards certain situations. Records showed that not all staff had completed this training but the registered provider informed us that there was an expectation that they would and the training was available to all. We noted from the information provided that only four staff had completed training in relation to record keeping and person centred care, 18 had completed Falls Awareness, 27 Safeguarding, 21 First Aid, 25 Moving and Handling , 13 MCA/DoLS, 22 Dementia Awareness and 12 challenging behaviours. Staff also informed us that they had training around nutrition and catheter care which was not included on the training matrix. Dates for further training were provided following the inspection.

Inadequate

Is the service caring?

Our findings

People said that staff were "Kind", "Lovely" and "They are like my friends". Relatives said that they had no concerns as to how their family members were supported. They were complimentary about the staff and their continued commitment to the home.

However, during our visit we saw that not all of the staff interventions were positive. For example we witnessed a person being taunted by another individual but rather than being supportive staff said, "He's gonna come and get you ".It was not clear if the staff member was acting in " jest" but it triggered a reaction from other people who used the service who asked "Are we winding her up?". This therefore was not a caring or appropriate response to the situation.

The overall dining experience still required review and improvement. We saw that twelve people chose to sit at the dining table for lunch. Staff started to take some people through to the dining area at 12.05 but food was not served until 12.50. A number of these people expressed impatience or discomfort as they were sat for almost an hour with the smell and promise of food. Two people got up and walked off as they said "I have had enough of sitting here" and "That's it, I am not waiting any more". No snacks or nibbles were served in the interim to keep people's attention or to stimulate their appetite. Tables were not laid with table mats or covers, making the surface slippery. One person improvised by placing their paper napkin under their plate to stop it from moving on the polished surface. Condiments were not placed on tables to enable people to flavour or add additional seasoning to their foods.

Where people did not like the meal they had been served, not all were offered an alternative choice. This was dependent upon the staff member who supported them. The inspector had to intervene and request an alternative for one person as they had expressed not being able to chew their sausages and staff simply said "Just eat the veg then".

Signs for staff to remind them about a person's needs in relation to washing and pressure mattress settings were stuck to the backs of doors or wardrobes. This did not afford a person's dignity or confidentiality of personal information.

Records were kept where people had behaviours that challenged. These did not always give a clear indication of what had occurred but also the terminology used such as 'shouting' 'aggressive', 'kicking off' and 'was in her face' was not representative of a dignified approach. Some people had regular verbal altercations but rather than finding ways of managing these situations staff viewed these behaviours as normal despite the emotional impact they caused.

Simple things within the environment did not afford a caring approach towards people. This included us finding that two light bulbs were missing meaning people had dark rooms, rooms were not clean and call bells were not available.

Staff expressed affection for those people that they supported. Staff spoke to us about the CQC report and

told us that they stayed at the home as they wanted to ensure that people were safe and cared for. Other observations indicated that some staff treated people with dignity and patience. We observed a number of people being assisted to move with the use of a hoist. This was done at the persons own pace. Staff took time and explained what they were going to do and how in a gentle manner. Staff also responded to peoples request to have cushions, drinks or to use the bathroom.

We observed staff joining in with activities and encouraging people to have fun and laugh. This was a positive experience for those people who joined in.

Inadequate

Is the service responsive?

Our findings

People said that staff looked after them and they had "No complaints". Relative's comments included "Things are adequate but nowhere is perfect", "Caring staff are the thing that keeps the place going and us happy" and "They meet my [relatives] needs well so I cannot grumble".

At the last inspection, we found that records for care offered and delivered were not always accurate or sufficient enough to ensure that safe care and treatment was planned for people. Care plans were not detailed enough to enable staff to respond to people's needs. Systems were not in place to identify and assess risks to health and welfare. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). On this occasion we found that whilst some improvements had been made, there were on-going concerns. The registered provider informed us that the review of care plans was an on-going process and this accounted for the inconsistences in the content of the care plans.

There had been no new admissions to the home since the last inspection but people with nursing needs had moved to new accommodation. The staff had re-written the care plans for those people who remained in the home. Care plans were more detailed and person centred for areas of personal care and support. They contained more information on people's likes, dislikes and preferences. For some people, staff had also looked to seek more information about medical conditions or mental health issues to include the impact and management of this on the person. For example, a care plan had been drawn up to direct staff in managing a person's periods of anxiety and referred to what made them anxious and how to respond. However, this was not consistent and we found that some key aspects of a person's care and management were not addressed in a care plan.

At the last inspection, the registered provider had accepted people into the home whose needs fell outside of their statement of purpose by nature of age or diagnosis. We asked the registered provider to demonstrate how they would meet the needs of any such person. We looked at the care planning documents and found that they still did not contain adequate and sufficient information for staff to be able to monitor or respond to any decline in the person's health. The care plan made scant reference to diagnosis and its presentation. It referred to a person as having one particular mental health condition, when in fact the nature of their illness was coupled with an additional diagnosis which meant they were affected in a very different way. Staff did not understand the relevance of the powers of the Mental Health Act 1983.

People's care needs were not appropriately monitored putting them at risk of not receiving the right care and support. Charts were kept for the purpose of monitoring or oversight of people's health and wellbeing such as food and fluid intake, elimination and weights. These were not consistently completed. They were not reviewed by a senior member of staff in order to identify if there were any new or on-going concerns. This meant that records were not used to enable staff to monitor people's health and welfare or to make changes to ensure that people received the care and support they required.

Some people had health conditions or took medication that required monitoring and observation. Care

plans did not provide specific information in regards to the monitoring of health conditions. For example, records indicated that two people received support from staff to monitor their diabetes. For one person, a record from the GP indicated that blood glucose levels (BM's) were to be checked prior to a meal and ideally the time was to be varied. BM testing is essential to supporting necessary lifestyle and treatment choices and also to help monitor blood a person's glucose level. Records indicated that this was not the case and that in December 2016 10 of 12 days had readings taken around 7 -7.30 am. The requirements for monitoring were not included in a care plan. Another person frequently refused to have their BM's taken. There was no information to identify and mitigate the risks associated with continued refusal to have these checked. There was no information to guide staff as to what are the risk factors for someone with diabetes, the symptoms of high or low blood sugars or the actions they would take should BM's outside of the acceptable range. A number of other people took medication that placed them at risk of excessive bleeding or bruising. For example; warfarin. However, there was no information to direct staff as to what precautions or actions to take. This meant that the care provided may not be safe and effective in highlighting or addressing concerns.

We looked at the records of people who had a catheter in place. There were instructions in the care plan for staff as to how to fit and secure the catheter bag and how to maintain personal hygiene. Where a person had a history of the catheter blocking and the previous nursing care plans dated 26 October 2016 had provided some detail as to how staff were to observe and monitor this. This information had not been carried over into the new documentation to indicate the roles and responsibility of the care staff in monitoring this. The previous nursing care plan had stated staff were to record the catheter output at least 3 hourly and to record on the fluid balance chart. We looked at these records and saw that this was not being followed. For example, in December 2016 some days recorded only two entries over 21.5 hours period and three entries in a fifteen hour period. There was no oversight of the input and output of fluids and nothing to direct staff as to when to be concerned and to seek advice from the district nursing service.

Staff completed personal care charts to indicate throughout the week what support a person had been offered. These charts were not completed on a daily basis and other records could not confirm what support had been delivered. Some charts indicated that people had not received help with personal care, a bath or a shower for a significant number of days in a given month.

One person currently received their medication "covertly" (disguised or hidden). There was a care plan in place but this did not provide adequate guidance for staff as to how this was to be done. The plan stated that medication was to be crushed and mixed into foods. However, the manager informed us that it was not crushed but hidden in yogurt. This meant that there was a risk that the medication was not given in the correct way or in a consistent manner.

Some people refused or were reluctant to take their medication on occasions. There were care plans and risk assessments in place to highlight this but the information varied in its detail. The risks of not taking the medication, what should be done to encourage the person or when to escalate this concern were not always clear. For example, records stated that by not taking medication a person could suffer from a relapse in their mental health and that if they missed medication and suffered from ill health, a specific health care team were to be called. The care plan gave no indication as to how the person presented during this period of ill health, how many missed doses would be of concern or how staff were to offer support during this time. For another person, however, there was clearer guidance for staff to offer it again in half an hour but not to keep asking as it increased the person's anxiety levels.

The GP had seen a person on the 16 November 2016 as they were feeling constipated. The person's care plan had not been updated to reflect this and what, if any, actions staff were to take in terms of monitoring this condition despite staff being responsible for the administration of their laxatives. Records relating to

bowel movements were completed sporadically and failed to indicate where laxatives were administered.

Where a person had a visual impairment but there was no information in the care plan as to how this may affect them. In one instance, the care plan for mental health stated that that the person sometimes had conversations with 'people who are not there'. No consideration had been given as to whether this could be linked to poor sight and visual misperception.

We spoke to a person over lunch time as they were struggling to eat. They informed us that they had new dentures and their mouth was sore. Their care plan dated 14 November 2016 had not been updated to include this information, stating that they did not have dentures at this time. This meant that staff may not provide the correct level of oral hygiene and support.

Not all of the people who lived at the service got along together and we observed friction at times. Staff completed behaviour monitoring forms for a number people but these were not reviewed to establish antecedents, behaviour patterns or reactions. They did not form the basis of any management plan to try to reduce occurrences and so they continued.

Within a diet and nutrition care plan it indicated that a person was able to go out independently and could return 'drunk'. However, there was no information as to how this may affect the person or the impact that it could have on others or staff. The aim of the care plan simply stated to ensure the person was 'well-nourished and hydrated'. A previous assessment by a mental health professional highlighted the consumption of excessive alcohol to be a key risk factor for this person in regards to their own safety and that of others.

These are a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 .The registered provider had not ensured that the risks to the health and safety of people were assessed and control measures were not in place to make sure that risks were as low as practically possible.

People and relatives said that they knew how to make a complaint, but not all were confident that issues would be fully resolved and addressed. We saw that two complaints had been formally raised since the last inspection. An investigation had taken place and a brief response provided for the complainant. The letters did not give detailed information as to the process of investigation or fully address all of the information contained within the letter. For example, a complaint made on the 14 October 2016 in regards to missed appointments. Although the issue has now been resolved; there was no explanation as to why/how these had been missed in the first instance. Another complaint had been made in regards to the frequency of a person's toileting. It was reported that the person refused to go when offered and the solution being that staff will take them on a regular basis. No consideration had been given to capacity, risk and choice or guidance from the continence service.

Previously, we noted that there was a lack of activity and stimulation for people within the home. The home had employed a person that came for two days a week to provide group and individual activities. People told us that they "Loved the days" that the person came and looked forward to it. Relatives also felt that this was a big improvement and that people "Lit up" when they came to visit. The person was also spending time with staff educating and encouraging them to carry out activities with people throughout the other days. We observed that people liked to join in the activities that had been arranged and also participated in a Christmas service that had been arranged with the local church.

Inadequate

Is the service well-led?

Our findings

People knew who the manager was and said that they "Liked her" and found her "Helpful and not scared to tell the staff off". Relatives also felt that the manager was "Proactive", "Approachable" and always available to discuss concerns with.

There was no registered manager in post. The manager at the home had commenced in August 2016 H. The manager has made an application to the CQC to become the registered manager. This assessment process has not yet been completed.

At the last inspection, there were shortfalls in the processes the registered provider had in place to assess, monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although some improvements had been made the systems put in place by the registered provider, the oversight was not robust.

The home had an infection control audit in place which had been undertaken by the manager. The completed audit did not reflect all of the findings in this report. Where issues had been identified, there was no remedial action plan in place. Nightly cleaning rotas were in place but only for weeks commencing December 6 2016, May 30, 23, 16 and 9, 2016. The manager confirmed that she had not checked that these had been done and signed as completed.

Care plans and risk assessments had been audited to ensure that they were completed and reviewed, but adequate checks had not been made on the content and accuracy of the information. There had also been insufficient checks undertaken on the supplementary charts and information crucial to monitoring a person's well-being.

There was a dependency tool in place to help inform staffing levels. We sampled 7 assessments for 6 people. However, checks had not been made to ensure that all of the information was correct. For example: the overall dependency matrix in the manager's office indicated that one person scored 14 but the individual assessment indicated a score of 21. We looked in detail and found that both scores were incorrect. Another stated that that a person had a communication score of 0 when the minimum score was 1. One person had 2 dependency assessments documents completed for the same time period but the scoring was not consistent. There is potential risk that the overall staffing levels would not be correctly determined if inaccurate assessments led to the wrong dependency rating. Since the inspection, the registered provider informed us that staff had been given further training in how to complete these correctly.

Accidents and incidents were recorded and some analysis carried out to look at themes and trends. However, we noted that some patterns had not been picked up and further reviewed. For example, we noted a number of incidents had occurred between two residents that appeared to take place around 6am – 7.30 am in the lounge area. This not been highlighted or further consideration given to minimising the risk. Over the period from August 2016 to mid-December 2016 there had been 11 incidents whereby people had sustained skin tears. There was no analysis of how these had occurred, whether the same staff had been on

duty or whether any care plans required review as a result. This meant that risks of further harm were not minimised.

The registered provider had engaged the services of an external consultant to assist him in monitoring the quality of the service. We found that the consultant had visited on a monthly basis looking at different areas of practice. There were no documented action plans following these visits where areas of improvement had been identified. This meant that there was no measure of overall improvement and compliance. The registered provider informed us that these were agreed verbally. We found, however, that concerns had not been rectified. For example, we have reported in effective on the requirement for care plans around DoLS and meeting any conditions imposed. The registered provider and manager had not considered this but the same issue had been highlighted in the consultant report of the 3 November 2016. Concern over some of the DNACPR records had been highlighted by the consultant in an earlier audit but not rectified.This meant that the progress against plans had not been reviewed to ensure improvements were made.

These are a breach of Regulation 17 of the Health and Social Care Act 2008 ((Regulated Activities) Regulations 2014 because the systems in place to assess, monitor and improve the quality and safety of the services were not robust and effective.

Checks had been put in place to monitor the use of pressure relieving mattresses. On the last inspection, we noted two of these to be incorrectly set. On this inspection, both were set at the same pressure setting as on the previous inspection. We brought this to the attention of the registered provider who made the statement that no one was in the bed at the time of us noting this and therefore there was no risk of harm. He stated he was confident that these would have been rectified prior to someone being put into the bed.

We found that the registered provider now visited the service on a more regular basis and took a more active interest. He completed his own audit on areas where he felt more confident, sampled meals and checked to ensure that those delegated to complete audits were doing so in a timely manner.

Records relating to the management of the service were not all held securely and appropriately to ensure they could be accessed by authorised people when required. The office and filing drawers were not always locked when the room was unattended. The manager's desk was in front of the window viewable from the driveway but not all records were locked away at the end of the day. We could not find some daily records and staff also had difficulty locating them. This was because records and confidential information was held haphazardly. The manager and the registered provider had recognised that there was a lack of organisation and an administrator had been employed to help file, organise and archive information.

Staff said that they felt supported by the manager and she wanted to make positive changes. They said that they now had staff meetings and far more support than in the past. Staff also felt that they had the skills to care for the people at the home as they had less complex needs now that those who required nursing care had been relocated. Additional training had been provided which they had found beneficial. Staff meetings indicated that there were still issues of practice that needed addressing particularly in regards to documentation and accountability.

Previously, relatives commented that there was a lack of consistent leadership within the service and this had begun to impact upon people's care and treatment. They also said that they had not had any opportunity to express their views about the service and would like more contact with the owner. The registered provider and manager had held meetings with staff, people who used the service and their relatives. Relatives had a mixed view about these meetings and how useful they found them to be. Minutes of these meetings reflected some of the on-going tension that exists between some relatives and the

registered provider. A survey had just been sent out but responses not yet returned and collated.

The manager had notified the CQC about key events that occurred within the service in regards to serious injury, safeguarding and events that affected the overall care delivery. However, they failed to ensure that we were notified about DoLS applications where they had been approved. We brought this to the attention of the registered provider and manager and ask these be submitted. These were received following the inspection.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider had failed to ensure that care and treatment was provided in line with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider had not ensured that the risks to the health and safety of people were assessed and control measures were not in place to make sure that risks were as low as practically possible.

The enforcement action we took:

We cancelled the providers registration.

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 environment was not well designed and did not offer suitable adaptations to support the needs of people living with dementia or other physical impairment.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had not ensured that there were robust and effective systems in place

to improve the quality and safety of the service.

The enforcement action we took:

We cancelled the providers registration.