Maria Mallaband Limited

Troutbeck Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Troutbeck Care Home took place on 24 February 2017 and was unannounced.

At our last inspection in July 2016 the service was found to have made some improvements from the previous inspection. We rated it 'Requires Improvement' overall, with identified breaches regarding dignity and respect, good governance and staffing. The service was deemed to have made sufficient improvements for it to be taken out of 'special measures'.

This inspection took place in response to a number of safeguarding issues raised and concerns from relatives of people living at the service about care and support. We found these concerns were now beginning to be addressed through the increased management support and the actions of the acting manager.

Troutbeck Care Home is situated in Ilkley, West Yorkshire, and provides nursing or residential care for up to 54 people. At the time of our inspection there were 29 people living at the service. Of these, 22 people required nursing care and 7 people required residential care.

The service should have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently left the service and there was an acting manager in place who was intending to apply for the post of registered manager. The home was also being supported by the provider's Clinical Skills Development Manager, Senior Operations Manager, Quality Assurance Manager and Regional Director.

Staff were suitably trained in the safe administration of medicines. However, we found some shortfalls with staff administering medicines safely and providing an accurate record of their actions.

People told us they felt safe at the service, staff understood how to recognise and report signs of abuse and appropriate safeguarding referrals had been made. Incidents and accidents were documented, people's needs were assessed and plans put in place to mitigate risks to their safety.

The premises was reasonably well maintained although we saw some areas required some refreshing. Equipment was regularly serviced although two pieces of equipment to assist with the safe moving of people were out of service and awaiting parts.

There were sufficient staff deployed to offer people safe care and support although we were concerned about plans to reduce these numbers. A robust recruitment process was in place and staff training was up to date or booked, with all staff currently undergoing a refresher induction training programme. We saw the acting manager had a plan for staff supervision and appraisal.

The service was acting within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However we found staff had limited knowledge of this.

People were largely supported to consume a nutritious and varied diet although some food was served when it was not warm.

Plans of care were developed from initial needs assessments and these were reviewed regularly. However, these needed to be more person centred and care did not always follow these plans. Some charts relating to people's care were not always completed. Although care records were reviewed regularly, we saw little evidence of people or their relatives being involved in these.

We saw consent sought for care wherever possible, such as signed consent forms for care and support in people's care records and staff asking for people's consent before providing care. People's preferences were respected, such as where they wanted to spend their time, where they wanted to sit and what they wanted to eat or drink.

People's health care needs were largely met although there were some concerns from relatives about communication of some people's care and support needs.

We saw staff interaction with people was largely task focussed and some staff had a limited knowledge of people and their care and support needs. However we did see some caring interactions using verbal and non-verbal techniques and people looked smartly dressed and well groomed.

A plan of activities was in place depending on people's preferences. People's relatives and friends were actively encouraged to visit and were warmly welcomed.

Complaints were documented although these were not robustly recorded, analysed or followed up.

Staff morale was variable. We found people, staff and relatives were concerned about the lack of sustained management and provider support and the impact this had on the service.

Some issues we found at inspection had not been highlighted by the quality assurance process. This shows processes were not currently effective in addressing issues and driving improvements within the service.

A service improvement plan was in place; the acting manager was open and honest in their approach and determined to address the issues found at inspection.

We found the service to be in breach of a number of Regulations regarding providing personalised care, safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always administered safely and there were shortfalls in recording medicines administration.

The environment was safe although some moving and handling equipment was not in a good state of repair.

A robust recruitment procedure was in place to ensure staff were suitable to work with vulnerable people.

Sufficient staff were deployed on the day of the inspection although we were concerned about planned reduction in these numbers since many people had high dependency needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However some staff did not have good knowledge of this and the acting manager agreed this was an area for improvement.

A varied and balanced diet was available although some people's hot food at breakfast was not served immediately which meant it was no longer warm. Some staff's knowledge of people's food supplements was vague.

People's health care needs were supported with on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knowledge of people was variable and interaction with people was mainly task focussed.

People were treated with dignity and respect and their confidentiality respected.

People's independence was not always appropriately maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's plans of care were formulated following needs assessments. However care received did not always reflect these needs and care records were not always person centred nor did they contain sufficient detail to ensure consistent care and support.

We saw little evidence of people or their relatives being involved in planning or reviewing their care.

A complaints system was in place. However, documentation did not always reflect outcomes or resolutions.

People's preferences and choices were respected.

Is the service well-led?

Inadequate

The service was not well led.

People, staff and relatives were concerned over the lack of sustained management and provider support and the impact this had on the service. The service had had four registered managers over the last four years.

Staff morale was variable and some staff felt unsupported by the management structure.

There was a history of repeated breaches at the service over the last six inspections. Identified breaches should have been prevented through a robust system to assess, monitor and improve the service.

The provider had held meetings with people and relatives to discuss concerns and the acting manager was determined to improve the service.

Troutbeck Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 24 February 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist adviser nurse in Mental Health and Mental Capacity and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience in services for older people and those living with dementia.

We used various methods to gather and review information about the service before the inspection. This included reviewing notifications received from the service and information we had received about the service, speaking with the local authority contracts/commissioning team and the local authority adult protection team. We usually request a Provider Information Return (PIR) prior to inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had not requested a PIR on this occasion.

During the inspection we spent time observing care and support and spoke with four people who were living at the service and four relatives. We also spoke with the acting manager, activities co-ordinator, two nursing staff, eight care staff and the chef. We looked at elements of eleven people's care records, medicines administration records (MARs), three staff records and other records which related to the management of the service including training records, quality assurance processes, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Medicines were administered to people by nursing and trained care staff. We observed the morning medicine round. Staff wore a tabard indicating they were not to be disturbed whilst administering medicines which was largely effective. We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. However our observations of medicine administration records (MARs) demonstrated there to be shortfalls in the diligence of staff administering medicines safely and providing an accurate record of their actions.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system. We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge and room temperatures were taken and recorded. The rooms containing the medicine cabinets and trolleys were locked when not in use.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Our examination of the medicine administration records (MARs) showed there to be shortfalls in the management and administration of medicines. For example, we saw occasions where medicines were not signed for on the MAR sheet. One person was prescribed as statin which was not signed for on four occasions in February 2017 and another person had not had had their anti-psychotic medicine signed for on one occasion in February. An inspection of the remaining medicines in stock for these people suggested the medicines had been administered but not signed for. Whilst our observation of two staff on the day of our inspection showed the medicines to be competently administered, evidence from the MAR sheets showed this not always to be the case. We saw one person was prescribed eye drops to be instilled into both eyes for 48 hours. The MAR sheet recorded the eye drops had been continuously instilled for 13 days. Further observations of the signatures on the MAR indicated at least six staff had mal-administered the medicine over the period. We brought this to the attention of the acting manager who immediately contacted the prescribing GP practice. The practice confirmed the medicine should only have been administered for 48 hours. This demonstrated a lack of diligence regarding following provider and GP instructions.

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

Some medicines had been prescribed on an 'as necessary' basis (PRN). PRN protocols were in place to help nursing and care staff decide when and under what conditions the medicine should be administered. We witnessed the protocols being referred to when appropriate. The provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, we saw

protocols were in place for specific medicines such as warfarin where the dose is determined by periodic blood tests. We saw the results of the blood tests were available for the staff to refer to, thus ensuring the correct dose was administered.

Opening dates were recorded on all liquids, creams and eye drops which were being used and we found the dates were within permitted timescales.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

We found the premises was safe and suitable for its intended purpose. There were appropriate numbers of communal areas for people to spend time in which were furnished to a high standard and reasonably well maintained. However we noticed stains on many of the chairs in one of the lounge areas and saw this had been discussed at a recent relative's meeting. There was an enclosed garden area where people could spend time. People's rooms were comfortable and had been personalised to their individual requirements. However, we noted some rooms were in need of some attention. For example, the side of the divan bed in one person's bedroom was badly stained, in another the bed rail protectors were stained and some wall paper was scraped and coming off the wall behind a chair and in a third room we saw a chair had been taped up as a repair and there were stains down the inner side of the chair. A relative told us, "It used to be spotless (the room)." Another person's relative commented, "It's the detail; the chairs are worn." However, another person's relative told us, "It never smells, it looks clean."

A maintenance worker was employed and was responsible for keeping the premises in good working order and undertaking and managing safety checks. We checked documentation and saw checks were undertaken on key safety systems such as gas, electric, fire, and water and bed rails. This helped keep the building safe.

We saw the food standards agency had inspected the kitchen and had awarded the home 5* for hygiene. This is the highest award that can be made. This meant food was being prepared and stored safely and hygienically.

Lifting equipment such as hoists and stand-aids had recently been serviced following a safeguarding concern received about equipment in not a good state of repair. The servicing had identified one hoist and a stand aid were not safe to use. This stand aid was used by one person to aid their independence although the acting manager initially told us it had been serviced and was fit for use. The equipment had been serviced on 16 February 2017, staff told us it had been out of service for over a week prior to this and we saw it was still out of service on the day of our inspection on 24 February 2017 since the contractor was awaiting a spare part to return and bring it back into service. This also led to delays to care and support as only one hoist was functioning on the top floor but four staff were available. The acting manager had begun an investigation to determine why these issues with poor maintenance of equipment had not been pro-actively reported by staff. This meant at the time of the inspection there was not a full suite of lifting equipment available whilst these items awaited repair and meant one person could not use the aid which met their choices and preferences.

This was a breach of Regulation 9 (1), (3) (b) (i) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People and their relatives told us they felt safe at the service. One person commented, "Safe? Oh yes. They are very good here."

Staff we spoke with understanding how to identify and act on allegations of abuse. However two staff told us they did not always feel comfortable raising issues with the acting manager which along with staff not proactively reporting problems with the hoist did not provide us with complete assurance that all concerns would be reported to management. A current safeguarding investigation into concerns in the home was in the process being completed by the acting manager who was requested to share the findings with the Commission. Where the acting manager had identified concerns previously, we saw appropriate liaison took place with the local authority safeguarding unit.

Whilst care plans contained generic risk assessments to guard against poor nutrition, mobility and tissue viability, our examination of care plans evidenced risk assessments were also specific to people's individual needs. We saw these had been reviewed and updated accordingly. We tracked evidence of untoward behaviour and how staff responded in daily records, incident reports, behaviour records and medicine administration records (MARs). For example, we saw one person was of risk to others due to the nature and degree of their condition. We saw the use of antecedent-behaviour-consequence (ABC) charts as a direct observational tool to collect information about events regarding untoward behaviours. We saw staff recorded their observations before the behaviour was exhibited which included any triggers, signs of distress or environmental information. We saw the recent observations of staff had contributed information towards a multidisciplinary meeting with health care professionals to construct a responsive care plan and share it with relatives. The care plan demonstrated how the risks would be mitigated to respect the person's dignity and privacy whilst protecting others from harm.

A resident at risk report provided oversight of individual people's needs and their risk factors including weight loss and changes in their health to enable their safety to be monitored.

We spoke with staff about how they were recruited to the home. Staff told us they had to wait for Disclosure and Barring Service (DBS) checks, and reference checks to be completed before they were able to start work. Nursing staff confirmed they had to provide evidence of registration with the Nursing and Midwifery Council. We checked recruitment records for three staff including a registered nurse. These confirmed all the necessary checks had been undertaken. This meant the service had robust recruitment procedures in place to ensure staff were safe to work with vulnerable people.

Staff told us staffing levels were appropriate for the needs of the people that lived in the home. However, staff told us they were working to capacity and staffing levels would not be sufficient if imminent planned cuts to staffing levels took place. A staff member commented, "It's not enough. They (people living at the service) all need attention and care and some need the hoist."

Our review of staff rotas confirmed current levels were sufficient to keep people safe. On the day of our inspection, there were four care staff deployed on the first floor and three care staff of the ground floor, with a registered nurse and a care practitioner also on duty. We saw the service usually had seven or eight care staff on duty during the day with either two registered nurses or a registered nurse and a care practitioner. At night time, we saw there were four care staff and a registered nurse deployed. The acting manager told us they used agency staff to cover if necessary but used regular staff from the staff two staffing agencies to provide consistency.

However we were concerned about the increased risk to people's safety if staffing numbers were reduced, due to the high dependency rate of people. For example, on the day of our inspection 22 people required

two to one support with care. If staffing levels dropped to two care staff on each floor as proposed by the provider this would mean no staff would be available to offer people support or respond to call bells if these staff were busy in a person's room. A dependency tool was in place. However the acting manager told us this was not reflective of the high care and support needs of the people living at the service and did not reflect the lay-out of the building. They said they had proposed a system whereby extra staff were deployed during peak times, such as in the morning. However, they had not had this proposal agreed by the provider. This meant although current staffing levels were sufficient to keep people safe we could not be satisfied this would continue to be the case.

Accidents and incidents were recorded by the service and investigated to help keep people safe and prevent a re-occurrence. Following incidents we saw actions were put in place to keep people safe. We saw incident records were subject to analysis on a monthly basis to look for trends such as the time and location of incidents.

Requires Improvement

Is the service effective?

Our findings

People had access to a suitably varied menu which was all freshly prepared by the chef. At breakfast time people had a choice of cereals, toast or a cooked breakfast.

However during observations of care and support on the first floor we saw two people had ordered a hot breakfast sandwich. The eggs and bacon were brought up from the kitchen on plates covered by cling film rather than plate covers which would have preserved heat better. In both instances they were left on the side for over 10 minutes whilst staff attended to other people, before being made into a sandwich. This meant this food would have been cold when people received it. In addition we saw one of these people's care plans stated they should be offered encouragement to eat. We saw their food was left by their side with no staff present to offer encouragement for a further 10 minutes. This meant people were not always effectively supported with their dietary needs.

This was a breach of Regulation 9 (1), (3) (b) (i) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Where people were at risk of poor nutrition or had lost weight we saw appropriate referral took place to the GP. Measures were put in place to reduce the risk such as nutritional supplements and recording food intake. Information on people's dietary needs was present within their care and support plans in order for staff to support appropriately. However, when we spoke with some staff about people's prescribed thickening agents they were unsure of the amounts to be used, which did not provide us with assurance these would always be administered correctly.

At lunchtime, two main courses were available which varied on a four weekly basis. The menu was regularly reviewed and changes made based on people's preferences. The menu contained a good variety of meals, for example more traditional options such as fish and chips alongside dishes such as beef in red wine sauce and lamb curry. Lunchtime meals were followed by a dessert. We tried a sample of the lunchtime meal and found it looked appetising and tasted good. We saw tables in the dining rooms were attractively laid with cloths, napkins, condiments, matching cutlery and glass wear.

Some people were offered support by staff with their meals. We saw staff sat down to assist people and were patient in their approach. However, whilst observed one staff member engaging with a person whilst assisting with their food other staff did not make eye contact, were silent, or were task orientated in their interactions. This did not promote a positive and friendly atmosphere at lunchtime.

There were a number of lighter options available in the evening and the chef told us they often prepared additional items for people based on their individual preferences. Arrangements were in place to ensure kitchen staff were able to meet people specific dietary needs such as those that required a soft diet or these that were diabetic or vegetarian. Snacks were promoted throughout the day including fruit and cakes as well as regular drinks to keep people hydrated.

We saw people were offered a choice of meals throughout the course of the inspection with their choices relayed to the kitchen so appropriate food could be prepared. People gave us varying responses to when we asked about the quality and variety of food, with some people satisfied and others feeling more variety would be welcomed.

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

People can only be deprived of their liberty 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 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.

We saw six standard authorisations had been submitted to supervisory bodies for people at the home. Of these one had been granted with two conditions attached. We saw evidence both conditions had been actioned. Whilst we found matters regarding DoLS had been administered well in the past, our discussions with the acting manager demonstrated a lack of understanding of the MCA 2005 and the individual responsibilities of managers. The acting manager was unable to tell us how many people were subject to DoLS, how many authorisations they were awaiting and any conditions attached to granted DoLS. We spoke with some staff who were vague in their understanding of MCA/DoLS, were not able to tell us who was subject to a DoLS or who had had DoLS referrals made. The acting manager accepted they and other staff needed to improve their understanding and would take steps to do ensure this was done.

We spoke with the acting manager about the use of bed-rails. They were able to describe the procedure of risk assessments to ensure bed-rails were the least restrictive means of protecting people from risks associated with falling from bed. We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed-rails were used only to prevent people falling out of bed or where people were anxious about doing so.

We saw where issues around lasting powers of attorney required consideration in care planning this was clearly annotated in the care file. Care records showed the provider was ensuring inclusive consent procedures were being enacted in determining people's care needs. We observed staff communication with people during the medicine round. Staff communicated with people well and very clearly. They gave people options and spoke directly to their face so they could hear and understand what was being asked of them. Where people were seated staff knelt by their side. We saw staff asked people and obtained their consent before they did things for them.

Records showed arrangements were in place to ensure people's health and social welfare was protected. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency or when people's needs had changed. This had included GP's, hospital consultants, psychiatrists, community nurses, speech and language therapists, opticians and dentists. We spoke with the acting manager who told us the communication with the local GP practice who visited weekly had improved and they wanted to ensure this was maintained. We saw they had implemented a GP information form for staff to complete prior to the GP visits, containing relative information including the reason for referral. Some relatives expressed concerns about how their relatives' conditions were handled by the service. One relative expressed concerns about their relative's mental condition and how the service were dealing with it,

saying, "Troutbeck are not dealing with it [relative's condition]. [Relative] needs a review." Another person told us about confusion about their relative's medicines when they were admitted to hospital and the difficulty the medical staff at the hospital had in contacting the home to discuss this. This meant the communication around people's health needs needed to be improved.

Staff training was up to date or booked and included subjects such as fire awareness, moving and handling, health and safety, safeguarding adults, dementia, communication, nutrition/hydration and food safety. Other booked training included palliative care, syringe driver training and pressure care training. The acting manager told us they were also booking training in other specialist subjects such as Parkinson's disease to reflect the needs of people living at the home. All staff were partaking in refresher induction type training including the acting manager. This was in response to concerns raised about areas such as moving and handling, communication and person centred care. Training was provided through a mixture of eLearning, practical sessions and workshops. Staff told us the training was appropriate to their role and raised no concerns over training provision. However, the acting manager was aware knowledge in subjects such as MCA/DoLS needed to improve and we felt confident they would take steps to ensure this was actioned.

We asked the acting manager about staff supervision and appraisal records. They were unable to locate any records of these. Some staff we spoke with said they had not received supervisions and others said they had. However, we saw in staff files some supervision had been recommenced in 2017 and appraisals were booked.

Requires Improvement

Is the service caring?

Our findings

We observed some positive interactions within the home, for example staff comforting people using a mixture of verbal and non-verbal communication techniques to alleviate anxiety. People told us staff were kind and one person remarked, "I get everything I want. I'm quite happy with what happens to me here. I don't think I could be in a better place."

We observed people looked smartly dressed and well groomed, with well combed hair.

We observed staff mostly treated people with dignity and respect, knocking on people's doors before entering and speaking with them respectfully. One person's relative told us, "They have treated [relative] with respect and dignity; they have been fine but there is a lack of finesse." Staff we spoke with were able to give us examples of how they treated people with dignity and respect.

However we saw interactions were very task based and staff did not often have time to chat and talk with people. For example, prior to lunch on the day of our inspection we saw staff assisted people to sit in the bar area and asked them what they wanted to drink. Some people asked for juice, others sherry, wine or another drink and this was provided. However, we saw little engagement between people and staff other than this apart from one staff member who was trying to make conversation when other staff members were not present. When staff were congregated together in this area we saw they talked among themselves rather than chat with people. We overheard two members of staff discussing one person's hair and saying how nice it looked. However, they commented about this to each other rather than to the person themselves. We saw the service action plan talked about the need for staff interaction with people and social stimulation. Our observations concluded this was not always taking place.

We found staff had a variable knowledge of the people they were caring for. Some staff were able to tell us information about people's likes, dislikes and care needs. However other staff we spoke with did not know about people's pressure relieving regimes or how their drinks were to be prepared. People's relatives' comments also evidenced this. One relative commented, "Different staff put different amounts of food thickener in her feed; half a teaspoon, one, two teaspoons. They lack precision." This meant people were not always cared for by staff who were fully conversant with their care and support needs. Another relative commented on new and agency staff lack of knowledge of their relative, saying, "The nurse didn't really know [relative]. Didn't know that [relative] needs hearing aids and didn't know [relative] wears false teeth."

We saw one person was unable to use their mobilising aid due to it being in a poor state of repair. Their moving and handling care plan explained how they liked to use it to maintain dignity and independence, however this was awaiting a spare part before bringing it back into service. A complaint had been received about this from their relative. The person told us they had last been able to use the equipment two weeks prior to the inspection. They said, "The stand aid is broken on the foot plate. They use another one (hoist) which spins me around and makes me feel dizzy." Their relative commented, "It distresses [person]. [Person] needs the other one. [Person} needs it to help [person's] body to stretch out." This meant people's independence was not always appropriately maintained.

We observed some people's relatives were highly involved with their care and visiting was encouraged at all times. Visitors were welcomed in a friendly manner by staff and offered drinks during their visit. One person living at the service had a cat which people told us they enjoyed having around. We saw people's relatives and friends were encouraged to bring their pets for people to see and we saw people stroking and making a fuss of these. We saw some relatives brought young children and people greeted them with smiles and affectionate greetings. This showed a high level of involvement from people's relatives and friends in care and support was encouraged.

By reviewing people's care records, we saw end of life plans had been put in place. We saw where a person had elected not to discuss their wishes at present. This had been respected and documented as such. This showed the service supported people with their end of life wishes.

Care records and other confidential records were securely stored in locked cupboards and staff handovers took place privately. This meant people's confidentiality was respected.

Requires Improvement

Is the service responsive?

Our findings

During observations of care and support we saw people in their bedrooms had calls bells within reach so that they could summon assistance from staff if required. We saw these people had access to fluids.

Some people were deemed to be at high risk of developing pressure sores and required regular pressure relief. However we found some inconsistency in the care provided. For example, one person was on a turning regime with turn charts in place. However their care plan did not specify how frequently they required pressure relief and staff we spoke with either did not know how often it was provided or provided inconsistent answers. The person's turn chart showed pressure relief varied between two hours and over four hours. In addition, the person had an air mattress in place, but their care plan or the turn chart did not detail the setting it should be on. We saw another person's care plan stated they should receive two hourly positional changes. However, we saw on 21 February they had been turned at 02.05 and then at 0719, on 22 February they had been turned at 02.59 and 06.54 and on 24 February they had been turned at 02.00 and 07.00. A third person's care plan said they should receive two hourly pressure relief whilst in bed. However records showed pressure relief was sometimes not completed for over four hours, for example on 21 February at 06.00 and then 10.30. This meant people were not always receiving care which was responsive to their needs.

This was a breach of Regulation 9 (1), (3) (b) (i) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

A system was in place to log, investigate and respond to complaints. We looked at a sample of complaints received in 2017. A number of complaints had been received about care and support and most of these had been responded to. A review of complaint records, relative meetings and discussions with people and relatives led us to conclude a number of people were not fully satisfied with the service and had concerns which needed addressing stemming from a lack of consistent manager and oversight of the home.

We identified two complaints received in February 2017, which did not fully demonstrate the complaints had been resolved. In both cases there was no record to show the complaint had been discussed with the person and an outcome provided. The manager told us the complainants had been contacted but there was no record of these conversations.

One of these complaints related to a piece of equipment which had not been functioning correctly. The complaint documentation indicated the complaint had now been resolved as the equipment had been serviced. However when we spoke with staff they said the equipment was still not safe to use and we later confirmed this by speaking with a person who used the piece of equipment. This meant the complaint record did not accurately reflect the current situation. In addition, we looked in one person's care records and found that a complaint had been made in February 2017 about various aspects of care during a care review. However this had not been transferred to the complaints record meaning this was not officially counted as a complaint in the complaint records and there was no record of whether it had been resolved.

Two activities co-coordinators were employed by the home. During the inspection we saw them engaging in activities which included arts and crafts and a film afternoon. A range of activities took place, including dominos, films, board games, and external entertainers regularly visited. However many interactions we observed were rather task based and we saw there was not much going on in the home in the morning. Care staff told us they did not often have time to engage in activities with people as they were too busy. We spoke with one of the activities co-ordinators who told us they had one to one chats with people to find out what they liked to do and completed a daily activities file for each person. They told us they were planning to start a 'resident of the day' where they would do what that person wanted for that day. They told us trips and outside activities were dependant on staff numbers, but some people had recently been out for a pub lunch with staff.

We saw people's plans of care were put in place following risk assessments and pre admission assessment of needs. We saw these were easy to follow and understand and most were in a logical order with section for subjects such as maintaining safety, medication, socialising, mobility, mental capacity and personal information. Care records contained 'about me' information about people's lives, experiences, likes and dislikes so staff could learn about people's lives.

However, some care records needed further work to make them more person centred. For example, we saw one care record referred to the person as a 'him' when the person was a female. This showed the information used was generic in some cases. Some areas of the care records we reviewed referred to the person in the first person and others did not. Although regular care reviews were in place we saw little evidence of people or their relatives being involved in these and some relatives we spoke with told us they had not been involved with reviews or the planning of their relative's care. One relative told us, "It's two years since I sat down with a nurse to discuss [relative's] care plan." We spoke with the acting manager who acknowledged further work needed to be carried out to improve and personalise care records and we saw this was part of the service improvement plan.

We saw people's preferences were respected, such as what they wanted to eat or drink and if they wanted to spend time in their room or communal areas.

Inadequate

Is the service well-led?

Our findings

We identified a number of breaches of Regulation which should have been prevented from occurring through the operation of robust system to assess, monitor and improve the service. The service had been in breach of Regulations at the last six inspections and the breaches we found at this inspection were repeat breaches from the last two inspections.

Medicines checks had failed to identify gaps in MAR documentation and incorrect administration of eye drops. The equipment audit had failed to identify and action poor maintenance of equipment. For example, the stand aid on the first floor was out of service. Another hoist on the first floor was also out of action since the service was awaiting parts. This meant only one hoist was available on the first floor. This demonstrated issues with poor maintenance of equipment were not reported and acted on in a timely manner.

Complaints were not robustly recorded, analysed or followed up. For example, one complaint from a relative about the stand aid not working had shown 'stand aid serviced 17/2/17' as the outcome of complaint and there was no record of the relative being informed of this. Another complaint had been logged in the care records but not in the complaints record.

We were very concerned about the lack of strong leadership and management within the home. The home had had four registered managers in the last four years, with the previous registered manager having left in January 2017. This demonstrated a lack of sustained leadership at the service to monitor and drive improvements. We were told senior managers were providing support to the home and saw a human resources manager supporting the service on the day of our inspection. However, no other managerial support was provided to the manager during the inspection process. From reviewing previous inspections and discussions with the local authority we saw a pattern of provider support being given and withdrawn when the service appeared to have improved. Improvements were then not being sustained. This showed a lack of consistent and effective leadership and provider overview to drive and maintain service improvements. Staff and relatives we spoke with said this was unsettling for both staff and people living at the home. All the relatives we spoke with expressed concerns about the management of the service. A relative told us they thought the home lacked management and said, "The carers are not properly managed."

This was a breach of Regulation 17 (1) (2)(a) (b) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

Staff provided mixed feedback about leadership in the home. It was clear from speaking with staff there were some differences between groups of staff within the home and a number of staff felt morale was not good. One staff member said they felt bullied and didn't feel all staff 'pulled their weight.' Another staff member said of the acting manager, "I don't feel I can go to her," and another told us they did not think the home would change for the better and commented, "There is no praise, no recognition for what we do." However, another staff member told us, "[Acting manager's name] can get things in place. I think [acting

manager] is a strong manager and is aware of what needs to be done." We found the acting manager open and honest about service improvements needed and they told us they had an 'open door' policy for both staff and people living at the service and their relatives.

Most staff were also concerned about a planned cut to staffing levels within the home. One staff member told us they were worried the needs of people living at the service did not tally with the proposed levels of staff. They said, "Complexity of service users hasn't dropped. It isn't safe with the levels they're proposing." Staff told us they were also worried about the current embargo on new admissions and this was causing stress.

Following recent concerns identified through safeguarding alerts and internal audit processes, additional management support had been brought in to support the new home manager. A service improvement plan had been generated based on concerns and recent audit findings to help improve the service. To help resolve current quality issues within the home, a system of increased audits and increased frequency of staff meetings had been put in place along with further staff training to address identified shortfalls. A recent resident and relatives meetings had been held to discuss people's concerns and agree a way forward.

A range of audits and checks were undertaken. A number of checks were carried out by senior managers who had been supporting the home; for example, recent care plan and medication audits. These had identified a range of issues many of which similar to those identified by us during the inspection such as the need for care and support plans to be more specific about people's care and support needs. All care and support plans were due to be audited by March 2017 and actions had been set for completion by mid-March 2017. It was clear some improvements had been made to address quality issues and others were actions in progress.

Audits had taken place in other areas such as daily care charts, incidents, the home environment as well as observations of care and support. Action plans had been generated which were being worked through. A recent training audit following concerns raised about the care and support had identified the need for additional training for all care and nursing staff which we saw was in the process of being carried out.

A new call buzzer monitoring system had been introduced to allow the manager to monitor the response time to call bells within the home. Whist this was operational, there was still further work required to use the system in a meaningful way to monitor response times. Although the system monitored call bell response times, it did not record the time staff took to respond to a person's falls sensor mat sounding, despite being connected to the same system. We heard one person's falls mat sensor had been sounding for at least one minute at 1535 and noted a member of staff came at 1540. Within this time period, the inspector had to intervene to comfort and advise the person against attempting to stand without assistance due to the falls risk. The person was visibly distressed. We raised this with the acting manager who told us they would investigate.

The residents' survey from 2016 was yet to be published although a recent residents and relatives meeting had been held. We looked at the minutes which showed people's concerns had been clearly recorded. It was clear from the minutes that a number of people had concerns about the quality of the service and particularly the lack of leadership and regularly changing management arrangements within the home. One relative told us, "There is a lack of continuity. The manager, you get to know them, then they leave." This showed further work was required to address people's feedback about the service. However, we saw the acting manager had introduced a feedback box with comments cards in the reception area to help facilitate this.

We saw a multidisciplinary team quality assurance survey was carried out in 2016 and returned by five people. This showed a general level of satisfaction with comments about how the service was friendly, supportive and receptive during GP visits, although some concerns were raised about the risk of the service 'taking people with too complex needs before the team was adequately robust'.

We saw results from the staff survey in 2016 raised some concerns over some staff using personal mobile phones whilst on duty within the home. This had been also raised as a concern to the Commission prior to our inspection so we concluded this practice was still occurring and meant any actions taken had not been fully effective. Staff meetings had been planned although one staff member told us a recent meeting had been cancelled. The registered manager told us they met with staff each morning to ensure everyone was kept up to date although a staff member told us this was not always happening.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care; The care and treatment of service users did not always reflect their needs and preferences. Regulation 9 (1), (3) (b) (i) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines; medicines were not always administered or recorded safely or properly. Regulation 12 (1) (2) (g), Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance; The service had a lack of robust and sustained systems to assess, monitor and improve the service. Regulation 17 (1) (2)(a) (b) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

The enforcement action we took:

Issue warning notice.
Meet with provider.