HC-One Limited

Leighton Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection on 1 and 3 December 2015, breaches of legal requirements were identified. These breaches related to unsafe medication management, a lack of staff supervision and support, a lack of appropriate systems to ensure people's legal consent was obtained and ineffective management and governance. We asked the provider to take appropriate action to ensure improvements were made.

We undertook this comprehensive inspection on the 12, 13 and 17 January 2017. During this visit we followed up the breaches identified during the December 2015 inspection. We found that sufficient improvements to the way medicines were managed and how people's consent was sought, had been made. We found however that although staff now received regular supervision, they did not always have an annual appraisal of their skills and we found that no appropriate action to ensure that the service was effectively managed had been taken. This was a continued breach of Regulation 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also identified new breaches of the Health and Social Care Act 2008 with regards to Regulations 9,10 and12, These breaches related to the management of risk, the delivery of person centred care and poor staffing levels. You can see what action we told the provider to take at the back of the full version of this report.

Leighton Court Nursing Home is a purpose built building close to Liscard town centre in Wallasey. There are 48 single occupancy bedrooms. The home provides support for people with both nursing and personal care needs. The home also provides an intermediary care service. This means the home offers support to people discharged from hospital but who need a period of rehabilitation before they are ready to return home independently. There are 25 beds reserved for this purpose on the first floor. At the time of our visit, there were 45 people who lived at the home.

There was both a home manager and a registered manager in place at the home at the time of our inspection. 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 home manager had overall managerial control of the service with the registered manager acting as the deputy manager at the time of our visit.

We spoke with eight people and two relatives during our visit. All of the people felt safe at the home and said staff treated them well. A relative however felt that the care of their loved one required improvement.

We looked at the care records of eight people. We found that people's care plans did not cover all of their needs and lacked clear information about the management of some risks. We found that some of the risk management actions had not been acted upon consistently, to protect people from harm. Where people had challenging behaviours, appropriate risk assessments had not been completed to ensure people were

appropriately supported. Dementia care and aspects of some people's person centred care was poor with care plans lacking adequate information on people's emotional and social needs.

We found the provider's emergency procedures needed improvement to ensure people were safely evacuated in the event of an emergency. This was because the personal emergency evacuation plans in place for each person who lived at the home, were sometimes inaccurate and out of date.

Staff had been recruited safely but some staff member's criminal conviction check had not been renewed since they first commenced in employment. For one member of staff this was six years ago. This meant there was a risk it could be out of date.

We looked at the support and training arrangements in place for staff and found gaps in the appraisal of some staff members. This meant that some staff had not had their skills and competencies reviewed for some time. We checked staffing levels and found that at times they did not sure staff were able to provide safe and prompt support to people who needed it. There was no adequate system in place to ensure the number of staff on duty was sufficient.

People had access to adequate food and drink but people's feedback on the quality of the food and the choice of meals was mixed. Activities were provided but they were limited and the provider did not have adequate communal space to enable people to socialise appropriately. This placed them at risk of social isolation.

People's confidential information was not always kept secure and some of their information was displayed on their bedroom door for other people to see. This did not promote their right to privacy. Some people had difficulties communicating verbally but there was no evidence that any appropriate action had been taken to facilitate alternative means of communication so that they were able to communicate their needs and wishes to staff. This did not demonstrate that the service was caring.

Staff we spoke with had a general understanding of people's care but some staff were unaware of elements of people's needs. Staff had an understanding of signs of potential abuse and what to do should they suspect abuse had occurred.

When people became distressed, staff were seen to be caring, compassionate and patient and we heard people asking for people's consent before any support was given. We saw that where people's capacity to consent to decisions about their care may have been impaired, the Mental capacity act 2005 and the deprivation of liberty safeguard legislation had been followed to ensure legal consent to any decisions made, was obtained.

We saw that staff treated people kindly and spoke to them with respect. It was obvious that people felt comfortable and relaxed in the company of staff but some people said they would like to spend more time with staff but staff were always so busy.

The home was clean, safe and well maintained. Equipment in use had been certified as safe and regular health and safety checks on the premises and the equipment were undertaken.

Medications were administered safely and in a kind way. We checked the stock of medication against people's records of what had been administered and found they were correct. This indicated that people had received the medicines they needed and people we spoke with confirmed this. We found that there was an excess stock of nutritional supplements and fortified drinks and we spoke with the nurse on duty about

this, as this indicated that the ordering of these items required review.

We checked safeguarding and complaint records and saw that any safeguarding incidents and complaints received had been investigated and properly responded to.

The provider had a range of audits in place to check the quality of the service. The systems in place however were ineffective as they failed to pick up the areas of concerns that we identified during our visit. There were also limited opportunities for people to be given information about the running of the service and to share their views on the care provided. This meant there were no suitable mechanisms in place to enable the provider to come to an informed view of the quality and safety of the service provided. This indicated that the management and leadership of the service required improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's individual risks were assessed but there was a lack of clear information and risk management advice for staff to follow in the management of some risks.

The provider's emergency procedures did not ensure the safety of all of the people who lived at the home in the event of an emergency situation.

Staff were recruited safely but the number of staff on duty was not sufficient to meet people needs at all times.

Staff knew how to spot and respond to potential abuse and people said they felt safe.

Medication was safely administered and people had received the medication they needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people were identified as lacking capacity the principles of the Mental Capacity Act 2005 and DoLS legislation had been followed.

Staff had been trained and supervised but there was no evidence that some staff had received an annual appraisal of their skills and abilities.

People were given enough to eat and drink but people's feedback on the food was mixed.

The premises were not suitable for people's social and emotional needs as communal space was limited after a recent renovation to the home.

Is the service caring?

Requires Improvement

The service was not always caring as people's right to privacy

and dignity was not always maintained.

People's confidential information was not always kept secure and some information was displayed in people's rooms in an inappropriate way.

People who were not able to communicate verbally had not been supported to access alternative means of communication so that they could make their needs and wishes known.

There were limited mechanisms for people to receive information about the service and share their views.

People said staff were nice. We observed staff to be kind and respectful. Interactions between people and staff were positive and people were relaxed and comfortable in their company.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always person centred and the delivery of care did not always meet people's needs or preferences.

People's care had been reviewed but people's reviews failed in most cases to provide staff with an adequate update on their needs and care.

People's social needs were met by some activities but access for some people was very limited. For some people there was a risk of social isolation.

Complaints had been responded to appropriately and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not well led.

Some of the quality assurance systems in place did not effectively identify and address the risks to people's health, safety and welfare.

Not all of the breaches identified at the previous inspection had been addressed and new breaches of the Health and Social Care legislation were identified at this inspection. This did not demonstrate that the service was well led.

People's satisfaction had not been consistently sought or sought in any meaningful way to enable the provider to come to an informed view of the quality of the service.	

Leighton Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 12, 13 and 17 January 2017. The first day of the inspection was unannounced. The inspection was carried out by one adult social care inspector and a specialist advisor in clinical care.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our visit, we spoke with a healthcare professional and the NHS Infection Control Team and asked for their feedback on the service. During the inspection we spoke with eight service users, two relatives, the home manager, the registered manager, four staff and a visiting healthcare professional. We reviewed a variety of records including eight care files, five staff files, staff training records, a range of policies and procedures, medication administration records and documentation relating to the management of the service.

We looked at the communal areas that people shared in the home and visited a sample of people's bedrooms. Staff practice was observed throughout our visit.

Inadequate

Is the service safe?

Our findings

We spoke with eight people who lived at the home and two relatives. All of the people we spoke with told us they felt safe at the home. A relative we spoke with however had some concerns about the care their loved one received. We discussed these concerns with the home manager and registered manager during the visit.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with two staff members about the safeguarding of vulnerable adults. Both staff demonstrated an understanding of types of abuse and the action to take to protect people from potential abuse.

We reviewed the care files of eight people. We saw evidence that the risks in relation to people's health and welfare were assessed and reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. We found that some people's needs and risks were managed satisfactorily but others were not. This placed people at risk of harm.

For example, we saw that one person was admitted to the intermediate care service (IMC) following a fall. Documentation provided to staff on the person's admission showed that they were at high risk of falling when getting in and out of bed. Despite this, the person's fall risk assessment made no reference to this and the person's falls management plan failed to advise staff how to minimise the risk of this occurring. When we checked the person's bedroom, we found that no suitable precautions had been taken to minimise risk and prevent harm. The person's bed had not been lowered or a crash mat placed by the bed to reduce the risk of injury should a fall occur and there was no assistive technology in place such as a falls detector to alert staff to when the person fell.

One person's admission information indicated they required the assistance of one staff member to mobilise. The person's dependency and mobility assessment stated the person was immobile and could not mobilise from one place to another. When we visited the person's bedroom, we found that they had a wheeled rolator in place which suggested they were mobile and a sign on the person's bedroom door advised staff that the person could mobilise independently without staff support. This information was confusing and contradictory. When we asked staff whether the person was mobile or immobile, we received conflicting answers. This lack of accurate mobility information placed the person at risk of inappropriate and unsafe care.

One person was nursed in bed, unable to communicate and at risk of malnutrition. Due to their recent weight loss, we saw that staff completed food and drink charts for this person daily to record how much food and drink they had consumed. We found that although the amount of food and drink was recorded, there was no evidence that the person's daily food intake was monitored in anyway by clinical staff to enable them to be assured the person's diet was sufficient. The records also showed that on many occasions no food and drink was recorded as being given to the person after 5pm until breakfast the next day. This meant there was a risk that the person had not had anything to eat or drink for a substantial period of time. This did not show that the person's risk of malnutrition was appropriately managed.

Some people had behavioural needs that sometimes meant they had episodes of distress or challenging behaviours. Where people had emotional needs or behaviours that challenged, there was no evidence they had been risk assessed and appropriate support planned. This meant there was no guidance to staff on how best to manage these risks should these behaviours occur.

We checked that each person had a personal emergency evacuation plan (PEEPS) in place. PEEPS provide staff and emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. They assist emergency service personnel to quickly identify those most at risk, where they are most likely to be in the home for example their bedroom location and the best method by which to secure their safe evacuation.

We found that people's PEEPS lacked sufficient information about people's needs and the support required to safely evacuate. We saw that whilst people's mobility needs were identified, their mental health needs for example, confusion, challenging behaviour which may impact on their ability to escape unassisted were not described. We also found that some PEEPS were inaccurate and out of date as they referred to people who no longer lived at the home. This was particularly concerning, as new people now occupied the bedrooms, to whom these PEEPS applied. This meant that should an emergency situation arise, emergency personnel would have incorrect information about some of the people at the home. This placed them at risk of harm.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

The home manager told us that during the day there was a nurse and four care assistants on duty on each floor. This meant in total that there were two nurses and eight care assistants on duty supporting the 47 people who lived at the home at any one time. They told us they had plans to increase the number of staff by one and this staff member would work between the ground floor and IMC unit on the first floor. During our visit, we observed that these staffing levels were at times inadequate and did not ensure people's needs were met safely or in a timely manner.

For example, we saw staff often had to leave the person they were supporting to answer call bells. The nurse administering medications would at times be interrupted to attend to other tasks and the activities co-ordinator was often required to support people with their personal care when they should have been undertaking activities. Some people sat in the dining room for 45 minutes before lunch was served, as it took staff that long to get other people who required assistance to the dining room for their meal. We noted that people's calls bells rang frequently and at times took several minutes to answer. For example, two people who had pressed their calls bell for help, waited for ten minutes before staff assistance arrived. One of these people had been left on the toilet.

We asked people who lived at the home whether staff came quickly when they pressed their call bell. Some said at times they did not. One person told us that they could be waiting for "More than ten minutes" for a staff member to come and that it made them feel "Very uncomfortable at times". Another person told us that they knew they should not take themselves to the toilet alone but had done so on several occasions as they sometimes had to buzz for a long time. They told us "Nobody comes".

A relative we spoke with told us they did not think there was enough staff on duty. They said "There are more staff about the place (today) because you (CQC) are here. I've never seen so many staff". They said they had spoken to the home manager about the lack of staff and that the home manager had said the home was "Overstaffed". They went onto tell us that when they visited at the weekend, they heard a call bell

ringing for over 15 minutes and in the end they shouted for staff to help.

We asked staff on duty if they felt there was enough staff to meet people's needs. One staff member told us that it was "Difficult to meet people's needs as nearly everyone needs two carers" to assist them. They told us that this had been brought to the home manager's attention. Another staff member said "No, not enough (staff) on duty". They told us that the majority of people required two carers to assist them and most required the use of a hoist to mobilise. We spoke with nurse on duty who confirmed that the majority of people on the ground floor required two carers to assist them at all times.

We asked the home manager how they analysed the needs of people to work out safe and sufficient staffing levels. They told that there was no formal method of determining whether the number of staff on duty was sufficient. This meant there was no analysis of any factors that could impact on staffing levels and the safe provision of care or treatment. This meant that the manager and provider had could not be assured that staffing levels were safe.

This evidence indicates a breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the number of staff on duty was insufficient to safely meet people's health, safety and welfare needs.

We found the home was well maintained and subject to regular health and safety checks by the maintenance officer employed by the provider. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected by external contractors competent to do so and they had been certified as safe to use. There was an up to date fire risk assessment in and adequate systems to monitor and mitigate the risk of Legionella in the home's water supply. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed.

We looked at the personnel files of five staff to check that they had been recruited safely. We found that they had. Two staff files related to nursing staff and we saw evidence that their professional registration with the Nursing and Midwifery Council had been checked and was up to date. Some of the criminal conviction information however in staff files had not been checked since the person was first employed. For example, one person's criminal conviction information was six years old which meant there was a risk this information was out of date. We spoke to the home manager about this.

We saw that people's medication was kept in a locked trolley which was stored in a locked room. We observed that the medication round took up a significant proportion of the nurse's time whilst they were on duty and that one medication round seemed to roll into another. This meant a significant proportion of clinical time was spent dispensing medicines.

We checked a sample of people's medication administration charts (MAR) and found that stock levels balanced with what medicines had been administered. This indicated that people had received the medicines they needed. One person commented that they often received their medications "Very late" at around 11:15pm. They said they would prefer to have them earlier so that they could go to bed earlier.

People who needed oxygen, had their oxygen in their bedroom but on the first day of our inspection, the oxygen canisters were not stored safely. We spoke to the home manager about this, and on the second day of our visit, this had been rectified. Tubs of prescribed supplements were located in the ground floor dining room which should have been stored in the medication trolley and we found some people had a lot of

prescribed fortified drinks stored in their rooms. Excess stock of these supplements and drinks were also found in the medication room. This indicated that the way these supplements were ordered by the home from the person's GP required improvement. We spoke to the nurse on duty about this.

Requires Improvement

Is the service effective?

Our findings

People told us the staff worked hard and did their best but that they were very busy. We observed staff supporting people throughout the day and saw that they had good relations with the people they cared for. We asked three members of staff about the care of one person at the home and found that although they had a general understanding of their needs, one staff member was not aware the person had dementia and differing accounts of the person's ability to mobilise was reported. This indicated that the method by which staff were made aware of people's needs and care was not sufficiently effective.

We reviewed six staff files and saw evidence that staff had received an induction when they first started working at the home. Staff training records showed that staff had access to regular training opportunities. For example, training was provided in safeguarding, moving and handling, the safe administration of medication, infection control, mental capacity, deprivation of liberty safeguards, nutrition and hydration, food safety and dementia awareness. Staff spoken with told us they felt well trained and supported in their job.

At our last inspection on 1 and 3 December 2015, we found that staff had not received appropriate supervision in their job role. This was a beach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we checked records relating to the supervision of staff and found staff members now received regular supervision with their line manager.

We found however that there was no evidence that some staff members had received annual appraisal of their skills and abilities. For example, one staff member had no appraisal documentation to show that their skills and abilities had been assessed since they commenced in employment in 2010 and another had no appraisal documentation subsequent to 2013. We asked the home manager about this, who told us that they were sure staff had their appraisal but acknowledged they were unable to provide any records to demonstrate this was the case.

This meant there was no evidence the skills and abilities of some of the staff employed at the home had been reviewed so that any learning and development needs could be identified and addressed. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home to be pleasantly decorated with appropriate signage on toilet and bathroom doors to enable people with dementia to recognise where these facilities were. The layout of the home was simple with one long corridor of bedrooms on each floor but peoples' bedroom doors were not clearly marked to make them easily recognisable. They contained the bedroom number and the name of the person but this signage was small, above eye level and all bedroom doors looked the same. The numbering of some of the rooms was also confusing. This meant it may have been difficult for people with dementia to recognise which bedroom was theirs.

There was inadequate space in communal lounges for people to sit and chat socially. The ground floor

lounge did not have enough seats for people who lived on this floor to all sit in at any one time. Another lounge on the ground floor was out of order on the day we visited and the communal lounge on the first floor only had seating for four out of the 25 people who lived on this floor at the time of our visit. When we asked a staff member about this, they told us that there used to a bigger lounge, but that the provider had changed this into a physical therapy room during a recent renovation. This meant the home did not have suitable space for people to socialise or entertain visitors.

Neither dining room on the ground or first floor had enough space to accommodate all of the people who lived on these floors at any one time. This meant there was a risk that some people may not be able to eat their meal in the dining room if they wanted to. On the first floor we heard staff asking people where they would like to sit but we observed that the dining room was cramped and some people had to be moved from one table to another, to accommodate others in wheelchairs who were unable to physically access other areas of the dining room due to space limitations.

This was a breach of Regulation 15 of the Health and Social Care Act Regulated Activities) Regulations 2014 as the provider had failed to take into account people's social needs when the premises were renovated and as a result communal areas where not suitable for the service provided.

We observed the serving of lunch and saw that some people waited for up to 45 minutes for their meal to be served. People sat patiently during this time and did not appear to become upset by the wait. Menus were displayed on a stand outside the dining room and during lunch we heard staff collecting people's orders for tea. We saw that people were given two options for lunch and tea. We found the dining room to be light and airy. Dining room tables were nicely set with table cloths and napkins. When lunch arrived, we observed that staff served people pleasantly and attended to their needs promptly. Staff chatted socially with people throughout their meal. People appeared relaxed and comfortable.

We asked people about the meals provided and the feedback was mixed. One person told us it was "Not very good" and that there were "Lots of casseroles and stews which gets a bit boring". One person said the food "Used to be terrible" but that it was better now and another said that the vegetables were "Overcooked and mushy" and the "Scrambled eggs watery". One person we spoke with told us the food was "Great" and another said it was ok.

At our last comprehensive inspection on 16 February 2016, we found people's legal right to consent to their care had not always been respected in accordance with the Mental Capacity Act 2005 (MCA). This was a beach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we saw that the required improvements had been made and the provider was now compliant with Regulation 11 of the Health and Social Care Act and the MCA.

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 made in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. We found that the correct processes had been followed to ensure people capacity was assessed in relation to specific decision making and deprivation of liberty decisions.

Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with said the staff were kind and caring. A relative's view was however mixed and they felt some staff were more caring than others.

During our visit, we saw some examples of the service that was caring and dignified but this approach was inconsistent and required improvement to ensure people's privacy and dignity was respected at all time.

For example, we saw that there were laminated signs on the outside of people's bathroom doors, referring to the person as a 'patient' and giving personal details of the mobility support they required. For example, one person's sign stated 'patient is independent to sit – stand and now independently mobile with a four wheeled walker'. This type of language depersonalised people. It did not show that staff were sensitive to people's feelings about being described in this way or cared that people's confidential information was on display.

We saw that people's care files were stored in a cupboard on the ground floor at the end of the communal corridors. At various times throughout our visit, this cupboard was left unlocked, which meant it was accessible to unauthorised people. This did not show that staff cared about people's personal information being kept secure and confidential. We noted that this had been drawn to the attention of the registered manager, home manager and provider at the last inspection. Despite this no effective action has been taken to preserve people's right to confidentiality.

When we looked at people's care files, we saw that their care records contained photographs of them. One photograph had not been taken in circumstances that respected the person's right to privacy or dignity as it had been taken when the person looked to be asleep. This meant that the person may not have been aware that they were being photographed.

During lunch, we observed one person struggle to keep food on their plate. Part of their meal ended up on the tablecloth. This person would have benefitted from a plate guard to maintain their dignity whilst eating. Another person was given a spoon to eat their meal but no other cutlery and we saw that this person used their fingers to push the food onto the spoon. This was not very dignified.

When we looked at the care files of people who lived at the home on a permanent basis, we found that they lacked information about people's preferences for how they would like to be cared for at the end of their life. Some people had do not resuscitate decisions in place but people's wishes in relation to their end of life care had not been documented for staff to follow. When we checked staff training records we saw that staff had not received training on how to support people who were at the end of their life. This meant that people could not be assured they would receive end of life care in line with their wishes.

People's care plans contained a dependency assessment with information about what tasks they could do independently and what they needed help with . We saw that people who required mobility equipment had this in place but when we observed people in the lounge or in their bedroom, we found that this mobility

equipment was out of reach. This meant that the person was unable to be mobilise independently without first calling for staff assistance.

We saw that the dates of forthcoming resident/relatives meetings were advertised in the entrance area of the home. We asked the home manager for copies of the minutes of the meetings. The home manager told us however that nobody had attended the meetings for some time. There was no evidence that the reasons why nobody attended had been explored. There was no evidence of any other mechanism put into place by the home manager to ensure that people had access to information about the running of the home and any factors that may impact on their care. This did not show that the home manager or provider cared that people had appropriate information and explanations about the service they received.

We saw that some people had communication difficulties which impacted on their ability to communicate with staff verbally. We observed one person get distressed trying to communicate their needs with staff. We found that staff were kind and patient, but had difficulty trying to interpret this person's needs. We asked the staff whether the person had a communication board. They told us no. A communication board is a pictorial system consisting of a set of pictures that are designed to convey a certain meaning or feeling for example, 'I am hungry' or 'I am sad'. They enable people with verbal communication difficulties to communicate their needs, wishes or feelings to staff.

We asked the home manager if the other person with communication difficulties had a communication board. The home manager told us they did not. We looked at this person's care plan and saw that their care plan stated for the person to have a pen and paper to communicate their needs. We visited this person and this method of communication was not used.

This meant that no consideration had been given to the most suitable means of communication for these people so that they were able to engage in conversation and communicate their needs.

These examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

We saw that people sat in the communal lounge were comfortable, well dressed and clean which showed staff took time to assist people with their personal care needs. We observed that staff knocked on people's doors before entering and used people's names whenever they spoke with them. Those who lived at the home looked comfortable and relaxed in the company of staff.

We observed staff interacting with people who lived at the home and saw that they were respectful, pleasant and patient. When one person became distressed, staff offered kind words and reassurance to try to alleviate the person's agitation. During lunch, we heard one staff member introducing new people to the home, to the other people around the dining room table so that they felt comfortable. This demonstrated that staff cared that people felt comfortable in their surroundings.

One person who was immobile was transferred from their wheelchair to an armchair in the living room using a hoist. This person was supported by two staff and we heard staff speaking to the person quietly and explaining what they were going to do before they commenced transferring them. The staff took their time and made sure the person was secure and comfortable before commencing the manoeuvre. This was good practice as it showed that the staff cared that the person wasn't made anxious or nervous by the transfer.

We saw that one person liked to sit by their patio doors in their bedroom which looked out into the garden.

The home manager told us that the person liked the garden so they had arranged to have patio doors fitted so that they had a better view and access. This showed that the service had cared about this person's emotional well-being.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said they "Couldn't fault" the care they received. Other people we spoke with said they all felt comfortable in the home. One person said that whilst the staff were "Lovely" sometimes they were "Too busy to chat" and another said "They're very busy. Sometimes no one pops in for ages". Several people said they would like to spend more time with staff.

In the eight care files we looked at, people had numerous care plans about their needs. Some care plans and risks assessments were repetitive, duplicated, at times contradictory and inaccurate and it was difficult to get a true sense of the person and their needs. For example, one person had communication difficulties that meant at times they were unable to communicate verbally. On the day of our visit, we observed this person struggle to communicate. When we checked their communication care plan, we saw that it incorrectly advised staff that they were able to communicate verbally and speak clearly. This placed the person at risk of receiving care that did not meet their needs. We found that some of the language used to describe this person, their needs and behaviour was abrupt, did not demonstrate that the service understood this person's needs and did not show a compassionate person centred approach to their care.

The admission assessment for one person who was accessing the intermediate care service had not been completed properly or in full. This meant there was no adequate assessment of the person's needs and preferences to ensure the person's plan of care was designed to meet them.

We saw that care plans contained some information in relation to people's preferences for example, what time people like to go to bed, what drinks they preferred and what social activities they liked for example, reading books or watching certain movies on the television. We saw however that this information brief and had not been expanded upon in the delivery of care.

We also found that where people's preferences had been noted, they had not always been respected. For example, one person required a soft diet and we saw that this had been given in accordance with professional guidance and the person's dietary preferences obtained and documented on a dietary notification record. We found however that the person's diet notification record showed that the person did not like curries or fish yet when we checked the person's food chart, we saw that the person had been given fish on Friday on a regular basis. This was concerning as the person was no longer able to communicate so was unable to tell staff that they did not like the meal being provided. This demonstrated that although the person's preferences had been obtained, the care provided had not centred on ensuring these preferences were met.

We found that overall dementia care planning was poor for those people who lived with dementia. Staff had little information in people's care plans with regards to the specific ways this condition impacted on day to day life, how their dementia presented, or the impact of the dementia on their mental and emotional well-being. This meant staff had little guidance on how to provide person centred dementia care.

Care plans and risk assessments had been dated as regularly reviewed but the majority of people's reviews

stated simply that the person was 'happy with the plan of care' and failed to update staff on any decline or positive progress in respect of the person's needs or care. The handwriting on some of the documentation was also unreadable due to the quality of the handwriting and we found most of the monthly reviews meaningless.

The home had an activities co-ordinator who provided group activities to people each day on the ground floor. These activities were advertised on a noticeboard on the entrance to the communal lounge. The information displayed was written in small print and easy to miss. There were no activities provided to people on the first floor who were on short term intermediate care placements at the home. Should people who lived on the first floor wish to join in, they had to come down to the ground floor. Whilst this was not unreasonable, some of the people accessing the intermediate care service had mobility issues that could have impacted on their ability to access the ground floor without staff support.

The communal lounge room in which activities were provided was not big enough to accommodate more than approximately 10 people at any one time which made it difficult for the majority of people who lived at the home to access the activities. The seating in the lounge was arranged around the room which was not very sociable and did not encourage people to chat and interact with each other.

During our visit, we observed the activities co-ordinator providing activities for people in the communal lounge. On day one of our visit, a game of Jenga was offered to people on an individual basis and chair based exercises were undertaken. On day two a blind folded tasting test took place and on the third day of our inspection we saw that a small group of people were enjoying cookery in the dining room. The activities co-ordinator worked hard to encourage people to participate and keep them engaged in the activity on offer.

People we spoke with had mixed views about the activities provided. One person told us that "Unless you like board games or bingo there isn't much to do". Another person told us they spent most of the day looking out of the window and that they didn't "receive much input" from staff. A third person we spoke with said they were "Bored silly".

We were also concerned about the risk of social isolation for those people nursed in bed or those with communication difficulties who were unable to chat socially with others at the home. We observed that they received very little one to one time with staff. There was only one activities co-ordinator for 45 people. This made it almost impossible for the activities co-ordinator to engage in any meaningful way with people nursed in bed, people with communication difficulties or people who simply did not want to join in group activities. From our observations, these people appeared to only receive time with staff when they needed practical support with personal care for example, when they supported to eat a meal or when they required repositioning. We asked the activities co-ordinator about this. They confirmed our observations.

We saw that one person who was nursed in bed and unable to communicate, spent almost all day alone in their room. They did not have visitors during our visit and we saw that the only time staff visited them was when they needed support with personal care. We asked the activities co-ordinator about this and they told us they were unable to spend more than ten minutes a day with the person. They said there was approximately six other people on the ground floor who also would benefit from one to one time but they just didn't have the time. They said they were often disturbed when providing activities and required to help people who required support and help the care staff with lunch and breakfast. During our visit we observed this to be true.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 as the provider failed to ensure people's received person centred care that was designed to meet their needs and preferences.

We checked that the home manager and, or, the registered manager had responded to any complaints they had received in an appropriate and timely manner. We found that they had.

Requires Improvement

Is the service well-led?

Our findings

People thought the service was well managed. When we asked a relative they thought the management of the service required improvement.

We checked to see what arrangements were in place to monitor the quality and safety of the service provided. We saw that the home manager had a range of regular audits for this purpose. This included an audit of care plans, health and safety, environmental audits, equipment audits, accident and incident audits and medication audits. We found that none of the audits completed by the home manager were effective in identifying the areas of concern we had found during our visit.

There were no adequate systems in place to ensure staffing levels were sufficient and during our visit we observed that staffing levels were not always sufficient to meet people's needs. Systems in place to ensure people were safely evacuated in the event of an emergency were inaccurate and out of date. Recent renovations undertaken failed to consider the impact on people's life at the home and failed to recognise that communal areas were no longer able to meet the majority of people's needs.

There were a number of inconsistences in people's care records about their needs and risks and care files contained duplicated information that made them cumbersome and difficult to read. Despite this the care plan audits in place failed to identify these issues and failed to ensure information about people's needs and preferences was correct and complete.

We found that the breaches identified at the provider's previous inspection in December 2015 had not all been responded to appropriately, to ensure the running of the service complied with the Health and Social Care Act and at this visit, new breaches of the health and social care legislation were also identified. This did not demonstrate the service was well -led. For example, the service continued to breach Regulation 18 of the Health and Social Care relating to support and development of staff as there insufficient evidence to show that staff at the home received a regular and consistent appraisal of their skills, abilities and development needs.

People's social and emotional well-being was not protected as care plans failed to describe the support people required with regards to their emotional needs or dementia care and people did not access to suitable activities to protect them from social isolation. People's right to confidentiality was not always respected and people's needs not always described in an appropriate way.

People ability to communicate was also not always facilitated appropriately and there were no adequate mechanisms for people and their relatives to feedback their views and suggestions in relation to the service. Resident meetings were not popular and were poorly attended if at all and the home manager had not organised for any other method of gaining people's views in a systematic way. For example through an annual satisfaction questionnaire. This meant there were no effective systems in place to enable the provider to come to an informed view of the quality and safety of the service.

These issues indicated that further improvements to the way the service was managed were required in order to ensure that the service was safe, effective, caring, responsive and well-led. This meant the service continued to breach Regulation 17 of the Health and Social Care Act relating to good governance.

At the end of our visit, we discussed some of the concerns we had identified with regards to the service with the home manager and registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's received person centred care that was designed to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people using the service were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to take into account people's social needs when the premises were renovated and as a result communal areas where not suitable for the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The number of staff on duty was insufficient to safely meet people's health, safety and welfare needs. The provider had not ensured that the skills and abilities of some staff had been reviewed so that any learning and development needs could be identified and addressed.