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Balliol Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection was unannounced and took place on 29 July 2015.

Balliol Lodge is a care home that provides nursing and personal care for up to 32 people. The care provided is for people living with dementia although some people have other enduring mental health needs. The home consists of two converted buildings over three floors. It is located very close to shops, local amenities and public transport links.

At the time of our inspection there were 23 people living at the home.

A registered manager was not in post. They had left the service shortly before our inspection. A new manager had started working at the home a week prior to the inspection and they intended to apply to CQC to register as manager. A registered manager is a person who has registered with the CQC to manage the service. Like

Summary of findings

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.

People told us they felt safe living at the home. There was variable understanding amongst staff about what adult safeguarding meant. Training records showed that the majority of the staff team were not up-to-date with safeguarding training.

People living at the home told us there were not enough staff on duty at all times. Visitors and staff said there were sufficient numbers of staff on duty at all times. From our observations there were enough staff and people's needs were responded to in a timely way. An activities coordinator had recently been recruited.

Staff recruitment processes were not effective. All relevant recruitment checks had not been undertaken prior to staff starting work at the home. Arrangements to check the on-going fitness to practice of staff registered with a professional regulator was not robust.

Medicines that were given to people without their knowledge had not been undertaken in accordance with the home's policy. There was no evidence to show that medicines given this way had been agreed through a best interest discussion with the person's doctor, family and with the involvement of a pharmacist.

The process to monitor staff training and supervision was not robust as there were conflicting messages between what staff were telling us and what the records showed.

People and visitors expressed mixed views on the quality of the food. There was a consistent view shared with us that there was insufficient choice at each meal time based on people's preferences.

Staff sought consent from people before providing personal care. Staff had not received awareness training regarding consent and mental capacity. They had a limited understanding of how it applied in practice. Mental capacity assessments were completed in a generic way and were not specific to the decision the person needed to make. Five people were on a Deprivation of Liberty Safeguard plan but CQC had not been notified of these.

People had access to a range of health care practitioners when they needed it.

We observed staff supported people in a kind, caring and unhurried way. Personal care activities were carried out in private. A keyworker system was in place. People without someone to represent them regarding their care and support had not been referred to advocacy services.

A complaints procedure was in place but not all complaints raised had been dealt with in accordance with the procedure.

Arrangements to monitor the safety of the environment and equipment were not rigorous as we found a number of concerns with many areas of the environment. For example, lighting was not working and windows did not close properly in some rooms. We tested the shower water and initially it was scalding to touch. It took 15 seconds for the water to cool down. This meant there was a risk of scalding if a person was under the shower when staff turned it on. Some areas of the building and items of equipment were not clean.

Staff were not always using the hoist correctly to move people. Training records showed very few staff were trained in moving and handling.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, feedback systems and the analysis of accidents and incidents. This put people's health safety and welfare at risk of being compromised.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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.

Medicines that were given to people without their knowledge had not been undertaken in accordance with the home's policy and with written agreement from the person's doctor.

Not all staff were clear about what constituted an adult safeguarding concern. More than a third of the staff team required training in adult safeguarding.

The arrangements for recruiting staff were not effective as some staff had started working at the home before checks to determine their suitability to work with vulnerable people had been established.

Some areas of environment were not safe, well maintained or clean.

Is the service effective?

Requires improvement

The service was not always effective.

It was not clear if staff training and supervision was up-to-date.

People received meals regularly. Snacks and drinks were available throughout the day.

Staff were not clear about the principles of the Mental Capacity Act (2005). Mental capacity assessments were not being completed correctly.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were caring, respectful and kind in the way they engaged with people.

People had not been asked their preferred gender of staff for providing personal care.

People without someone to represent them in relation to their care and support needs had not been referred to advocacy.

Is the service responsive?

Requires improvement

The service was not always responsive.

Choices at mealtimes were limited.

Some of the care records contained limited information about people's relationships, working life, hobbies, interests and preferred routines to support staff with getting to know each person.

An activities coordinator had been appointed and was in the process of developing an activities programme based on people's preferences.

Summary of findings

A complaints procedure was in place.

Is the service well-led?

Inadequate

The service was not well-led.

A new manager had started at the home and was applying to be the registered manager.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, feedback systems and the analysis of accidents and incidents.

The manager acknowledged that there were shortcomings with the service and had already started to make changes. However, it was too early to see the impact these changes were having in 'turning the service around'

Balliol Lodge Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection of Balliol Lodge Nursing Home took place on 29 July 2015.

The inspection team consisted of an inspection manager, two adult social care inspectors and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We had requested a Provider Information Return (PIR) prior to the inspection but this had not been returned prior to the inspection. A PIR 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 looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service and the local infection prevention and control team to see if they had any updates about the service.

During the inspection we spent time with four people who lived at the home and six family members or friends (referred to as visitors in the report) who were visiting their relatives/friends at the time of our inspection. We also spoke with the manager, a registered nurse, the housekeeper, the chef, activities coordinator and five care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for eight people living at the home, five staff recruitment files and records relevant to the quality monitoring of the service. We looked round all areas of the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Inadequate

Is the service safe?

Our findings

People that we spoke with during the inspection said they felt safe living at the home and said they were satisfied that staff supported them in a respectful way. A person said to us, "I'm secure with the other residents." Another person said, "They [staff] treat me okay." Furthermore, a person told us, "I have never seen them [staff] against us". People told us they would tell the manager if staff or visitors were in anyway unfair to them.

Equally, visitors said they believed their relatives were safe. They said they would report any worries. A visitor said if they had any concerns they would, "Discuss it with the person in charge". Another visitor told us, "I'd go to the manager or social services if I had any concerns."

We spoke with the registered nurse who had a good understanding of safeguarding matters and how they would address any allegations of abuse in accordance with local area procedures. We observed the adult safeguarding reporting procedure was displayed in the nurse's office. We asked to see the adult safeguarding policy and were provided with the policy folder for staff. The safeguarding policy was missing from the file. This meant staff did not have access to the home's policy on safeguarding should they wish to check out the details in relation to safeguarding. The manager said he would ensure the policy was replaced.

The care staff we spoke with about adult safeguarding were less clear in the way they responded to our questions about safeguarding. A member of staff said they understood safeguarding to be, "Anything that is out of the norm to be reported or anything you see to do with anyone here." Staff told us the safeguarding training was delivered through watching a DVD. They did not think the training DVD was up-to-date. A member of staff said, "It's not completely modern. The DVD is about 10 years old." The training monitoring record we were provided with showed that just 10 out of the 31 staff identified had completed adult safeguarding training.

Not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they got their medicines at the time they needed them. A person said, "I get my eye drops and tablets on time." Another person told us, "I get my medicines every morning." Visitors we spoke with said they had not been involved in decisions about the medication for their relative.

The nurse advised us that they administered the medication for both the people receiving nursing care and residential care. They said one of the care staff was trained in medication. The care staff could administer medicines to people receiving residential care but the nurse said this rarely happened.

Medication was securely stored in a small room that could be accessed from the nurse's office. The nurse's office was locked when not in use. A nationally recognised medication reference book (referred to as the British National Formulary or BNF) was available for staff to reference and it was up-to-date. We checked the arrangements for managing controlled drugs, how they were stored and the registers; these were accurate and up-to-date. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Medicine that required refrigeration was stored correctly and daily fridge temperatures were recorded daily. The temperature of the medicines room was also being monitored. We noted that supplementary dietary drinks were inappropriately stored on the floor and we highlighted this to the nurse at the time of our inspection. Arrangements were in place for the disposal of medicines.

We looked at the medication records for four people living at the home. There were some gaps in the information recorded, such as the section on allergies. Body map charts were used to show where topical medicines (creams) should be applied. Records were up-to-date for medicines administered.

We looked at the plans that were in place for two people who were prescribed medicine to be taken when they needed it (often referred to as PRN medicines). These plans lacked detail in terms of being clear about when the medicine should be given. This is important if people are unable to communicate verbally to inform staff of a need for this medicine.

We looked at the medication records for two people who were receiving their medicines covertly. Giving medication covertly means medicine is disguised in food or drink so the person is not aware they are receiving it. We could not see that a risk assessment and mental capacity assessment

Is the service safe?

had been completed specifically regarding the decision to administer medication covertly. In addition, there was no recorded evidence to suggest that a best interest discussion had taken place involving the person's GP, representative and pharmacist. The nurse advised us that it was likely the GP had given verbal consent to the administration of medicines covertly. We checked the home's policy on covert medicines and it clearly stated to 'obtain written consent and approval'. Furthermore, there were no care plans in place indicating how the covert medicines should managed for each person i.e. in what type of food or drink, what to do if the person refuses the food or drink the medicine is in.

One of the people living at the home used oxygen. A detailed risk assessment and care plan was in place regarding the safe management of oxygen for the person. The spare oxygen cylinder was not secured to the wall, which was not in accordance with the home's policy on the safe storage of oxygen.

Not ensuring effective safeguards were in place for the safe management of medicines was a breach of Regulation 12(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel records for four members of staff. The recruitment information held on file was inconsistent, which meant recruitment processes were not robust. An appropriate formal check (referred to as a DBS check) is required before a newly recruited member of staff starts working at a care home. This is to ensure staff are suitable to work with vulnerable adults. We were unable to determine if a DBS check had been completed for one member of staff as there was nothing on file in relation to the DBS. We observed that another member of staff had started working at the home over a week before references were received. There was no evidence in place to demonstrate that a reference containing concerning information about a member of staff had been followed up and their fitness to work at the home was risk assessed. We raised these concerns with the manager. He told us he was not working at the home when they were recruited and was unable to provide us with any information to show these people had been safely recruited.

Interview records were not consistently maintained. For example, there was no record of an interview taking place for two staff members. Other interview notes provided very basic information with no details of the questions asked at interview. There was no information in any of the records to suggest the applicant's competence, skills and experience for the role had been checked. There was no record maintained of how the applicants performed at interview. The manager had started working at the home on 20 July 2015 and advised us that they had not been formally interviewed for the post.

A process was in place to check the professional registration of the nurses with the Nursing and Midwifery Council (NMC). We noted that this check was undertaken on 15 July 2015. Arrangements to check the on-going fitness to practice of individual staff registered with a professional regulator was not robust. Appropriate measures had not been put in place to ensure people living at the home were not at risk when a member of staff's fitness to practice safely was identified as a concern.

Not ensuring robust recruitment processes and staff fitness to practice checks were in place was a breach of Regulation 19(1)(a)(b)(2)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had a detailed look at all areas of the building and were concerned about the maintenance, upkeep and cleanliness of the environment and equipment. We found that people's health, safety and welfare had been compromised.

On entering the building all members of the inspection team noted a strong smell of urine in the foyer. This too had been identified in an infection control audit carried out by Liverpool Community Health on 17 July 2015. Staff told us the smell was coming from a bathroom in the foyer. We could see that the bathroom had just been cleaned yet it continued to have an unpleasant smell. We opened a window in the bathroom and it would not close fully as the window did not fit the frame properly. The window was very dirty. A ventilation system in the bathroom was also dirty and did not work. We noted that tiles around the shower fitting were broken so could not be cleaned properly. The cleaning schedule in the bathroom was not completed or signed. We looked at another toilet and found the extractor fan was dirty and not working, and the cleaning schedule had not been completed since 16 June 2015. In a further bathroom we observed that the seal around the bath was cracked and dirty. There was no toilet seat in the bathroom on the mezzanine floor.

Inadequate

Is the service safe?

We found numerous windows in the building, including in people's bedrooms, did not close properly. For example, a visitor in one of the lounges asked for the window to be closed. The window did not close properly so cold air was getting in. The visitor said, "It gets draughty when the wind blows." In one of the bedrooms the clasp was broken so the window did not close properly. This meant the room could be cold on occasions for the person who used it.

We tested the shower water and initially it was scalding to touch. It took 15 seconds for the water to cool down. This meant there was a risk of scalding if a person was under the shower when staff turned it on. The two shower rooms on the top floor were not in use due to issues with the plumbing. The showers being out of action has been an on-going issue and was discussed at the last inspection. The manager said the problem was addressed a few weeks ago but had reoccurred and advised us that a plumber was visiting the day after our inspection. We observed that the concern around showers not working had been raised through a staff satisfaction survey in July 2014.

In one of the bedrooms the radiator guard was loose and not properly fixed to the wall. We tested three overhead lights in bedrooms and none of them were working.

One of the bedrooms had two windows which opened from the bottom so could easily be climbed out of. The restrictors to prevent the windows from opening to an unsafe level were chains fixed with a screw and could easily be opened with a strong push. The manager advised us that the person living in the room was not mobile. However, this window could pose a risk to other people living at the home who may access the room or visitors to the service, such as children. We also found another window restrictor in a bedroom was broken. This had not been identified on an audit conducted on 23 June 2015.

We observed dust and dirt around various window sills and it appeared they had not been cleaned for some time. The lock on the door to the ground floor bathroom was encrusted with dirt. The housekeeper had cleaning rotas and they were signed and up-to-date. They told us they could not clean high windows as there was no ladder. They said this had been raised with the previous manager. Staff we spoke with said they did not think there was a formal cleaning schedule in place for the night staff. They said the night staff cleaned the chairs, vacuumed, mopped the floors and cleaned the dining room. Staff told us there was no schedule in place for the cleaning of equipment.

The housekeeper was wearing a uniform top that was dirty and stained. They told us they only had one uniform top and it was impossible to wash it when working three consecutive days. The housekeeper said they had asked the previous manager to provide additional uniform tops.

We looked at equipment, including specialist chairs hoists and mobility aids. We found many of these items to be stained and unclean. For example, a trolley a person used to mobilise was unclean with stains that appeared to have been there for some time. A person's specialist chair was stained. Staff told us they were unsure who was responsible for the cleaning of equipment. The fish tank contained dirty water and it appeared not to have been cleaned for some time. The fire safety guard in the main lounge was dirty and stained. A visitor expressed concern about the age of some of the furniture. They said, "Some of the chairs are wrecked. I picked up a dining room chair and the arm came off."

Not protecting people against the risks associated with the environment and equipment was a breach of Regulation 15(1)(a)(e)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the inspection team observed a member of staff using the hoist in a way that was not safe. The day after the inspection CQC was contacted by someone who had visited the service who said they had witnessed a member of staff moving a person using a hoist sling incorrectly and the person was shouting for the staff to stop. We checked the training monitoring record the manager provided us with. It showed that just two of the 31 staff listed had received training in lifting and handling.

Not protecting people against the risks associated with the unsafe use of equipment was a breach of Regulation 12(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to needs associated with memory loss some people living at the home were unsure about what we meant when we asked if there were enough staff on duty to support them. Other people said there were not enough staff. A person said, "People have to wait a long time. They are short of staff." Another person told us, "No [there is not enough staff]. They [staff] are very busy."

The views expressed by visitors regarding the staff levels were positive. They said there was enough staff with one

Inadequate

Is the service safe?

visitor telling us, "[Relative] never has to wait a long time. They [staff] come straight away." Some visitors acknowledged that the staff levels had been low last year but they said this had improved and there were more staff available to support people.

The staff we spoke with throughout the inspection told us the staffing levels were satisfactory. A member of staff said, "We could do with more staff but we can manage with the staffing levels." Another member of staff said, "We can cope at the moment with the staff we have. It's not about the number of residents; it's about their needs." We observed throughout the inspection that staff responded to people's needs in a timely way.

We looked at the records of incidents that had taken place in April and May 2015. The incident forms lacked information about the action taken following the incident and the measures to minimise a similar incident occurring again. This was further complicated by the use of two different incident forms; one included a section for action taken and further recommended action but the other form did not have this. This meant the consistent data was not being used to analyse incidents for themes and patterns

The majority of incidents related to altercations between people living at the home. Staff told us most incidents occurred in the lounges or dining room. They said they tried to prevent altercations by ensuring staff were present to observe people, such as a member of staff monitoring the lounge areas. A member of staff said to us, "You are watching them [people living at the home] all the time, watching for them hitting out at one another, watching out for signs." There were three lounge areas and a dining room being used by people throughout the day. It was difficult to see how the staffing levels could support constant monitoring of all the shared areas especially as we observed a number of people being supported by two members of staff when being moved using a hoist.

A range of risk assessments were in place in each of the care records we looked at. They included a falls risk assessment, bedrail risk assessment, nutritional risk assessment and a lifting and handling assessment. The documentation for a person who displayed behaviour that challenges lacked detail in terms of how staff should respond. For example, the care plan stated, 'Staff to monitor for triggers; keep challenging behaviour records; de-escalation techniques to be used.' A description of the triggers the person presented with and de-escalation techniques specific to the person were not defined. A member of staff clearly described the triggers for another person and the approach they used to diffuse the situation. However, this crucial information was not captured in a care plan. It is important to record such information to ensure a consistent approach is taken by staff. It is particularly important for new staff to the home that are unfamiliar with the people living there.

Requires improvement

Is the service effective?

Our findings

Throughout the inspection we heard staff seek people's consent before providing care. For example, we heard staff ask people if they wished to take their medication or use the bathroom. We noted from the care records that a consent form was in use to seek people's permission to take their photograph and for others to read their care plan.

Because most of the people were living with dementia, we looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) for the people who lacked capacity. This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Mental capacity assessments were contained in the care records we looked at. They were not being used correctly to identify specific decisions the person needed support with. For example, the reason for completing a mental capacity assessment for a person stated it was for 'safe aspects of care'. A further form stated '[person] can make simple decisions but not make any complex decisions'. There was no clarification as what the complex decisions the person needed support with making and who would support them. There were no records to suggest a best interest discussion had taken place for the complex decisions that needed to be made. We made a recommendation at the inspection on 22 July 2014 regarding mental capacity assessments being used incorrectly and there had been no improvement since that inspection.

We did not see that mental capacity assessments and best interest discussions had been completed for the people who used bedrails. This equipment can be considered a form of restraint so ensuring it is used in a person's best interest is important. Visitors we spoke with said they had not been involved in decisions about the use of bedrails for their relative.

The manager advised us that five people living at the home had a Deprivation of Liberty Safeguards (DoLS) plan in place. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. CQC have a responsibility for monitoring DoLS and providers are required to notify CQC when a DoLS has been authorised for a person. We checked our records prior to inspecting the home and no notifications in relation to DoLS had been received.

We had established that covert medication was not being administered in accordance with the law. This meant nursing staff were not familiar with medication practices in the context of the Mental Capacity Act (MCA). We talked with staff more broadly about the MCA and DoLS. They were unsure and a member of staff said, "I can't remember what either is." The staff we spoke with confirmed they had not received training in the MCA. The training monitoring record did not identify the MCA as a training topic.

By not adhering to the principles of the Mental Capacity Act (2005) was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living at the home how the staff supported them to maintain good health. They said the doctor came to see them if they needed it. A person said, "They send for the doctor sometimes. If I [become unwell] they know when to get my tablets." Visitors told us the nurse was good at ensuring any health concerns were addressed. They said the nurse contacted the doctor in a timely way when their relative needed it.

The care records we looked at showed regular input from a variety of health care professionals depending on people's individual needs. Some people had diabetes that required regular blood checks and we could see that these checks were carried out when the person needed them.

We asked people living at the home about the meals and access to drinks/snacks throughout the day. The feedback from people was mixed. Some people said they liked the meals. A person said, "It is alright for me. I'm not a big eater." Another person told us, "It is good, average. I get enough. I don't feel hungry." Some people told us they were not happy with the meals and a person said, "It is rubbish. I don't like the veg." People also told us they could have a cup of tea when they wanted one.

Visitors expressed mixed views about the food also. A visitor told us, "[Relative] loves the food, he wants more." Another visitor said, "[Relative] likes the food. It always looks really nice." Other visitors were not satisfied with the food. A visitor said, "I don't think the food is of good quality." Another visitor said, "I had a meal once and that was

Requires improvement

Is the service effective?

enough. I once called in unexpectedly and the residents were having two overcooked fish fingers, oven chips and a blob of beans." Visitors we spoke with told us they had not been asked for their views or feedback on the food. A satisfaction survey completed by a relative in March 2015 stated they would like to see, "Better food and more of it."

A member of the inspection team had lunch with the people living at the home. They did not enjoy the meal. It was not very warm and the vegetables were overcooked. We observed that plenty of staff were available to support people with their meal.

We spoke with the chef who was new to the home. He had plans to review the menus to ensure more variety was available to people. He advised us that tea, coffee and fruit juices were available in the morning and the same in the afternoon, but with the addition of biscuits or cake. Cooked breakfasts and fresh fruit were available on request. This concerned us as most of the people were living with dementia and may not be able to ask for fruit or a cooked breakfast. We saw a jug of juice in the lounge but there were no glasses available for people to get themselves a drink.

With regards to staff training, there were inconsistencies between what a small number of staff were telling us and what the records indicated. The training monitoring record we were provided with showed large gaps in staff training. For example, of the 31 staff listed, 12 staff had completed infection control training, four had completed risk assessment training and seven had completed health and safety training. Training topics we would expect to see were not listed, such as medication, dementia care and behaviour that challenges. However, the nurse told us dementia training had been provided in the home and a community mental health nurses had facilitated a talk on behaviour that challenges. The manager had only been in post for a week before our inspection and could not be sure the training monitoring record we were provided with was up-to-date.

Equally, there were inconsistencies with what staff were telling us and what the records indicated in relation to supervision and appraisal. From the three staff files we looked at there was no evidence to indicate the staff had received an induction, whether they had received regular supervision or had an annual appraisal. However, a member of staff described their induction as adequate and said it involved a half day shadowing a member of the existing staff team and familiarising themselves with the people living there and the running of the home. They also confirmed that had received an annual appraisal and supervision three times a year. A supervision list for August and September 2015 was displayed in the nurse's office.

Training was mainly through DVDs and from our conversations with staff this was not a popular method of training. Staff said the DVDs were out of date. We observed from the staff meeting minutes of the 20 April 2015 that staff had highlighted to the previous manager that the DVDs did not always work. Staff indicated that DVD training did not provide the opportunity to talk things through. They suggested face-to-face training would be better. Staff said they completed an assessment to test their knowledge once they had watched the DVD and then the manager checked it.

Requires improvement

Is the service caring?

Our findings

People we spoke with said the staff were kind and caring. They said staff treated them with dignity and respected their privacy. One person said to us, "They [staff] are okay, they close the door." Another person told us, "When you ask them [staff] to anything, they do it for you." People also said that staff encouraged them to be independent.

People told us they had not been asked their preferred gender of staff for providing personal care. A person said, "There is always someone there to help you. I suppose we could choose." We did not see in the care records we looked at that people's preferred gender of staff to provide personal care was recorded. A member of staff told us there were three male carers employed at the home and they provided care to females but usually with a female carer present.

Visitors spoke highly of the staff. A visitor said, "The staff are lovely." Another visitor told us, "The staff are good. They do listen to me." There was no evidence in the records to suggest that people or their families were involved in regular formal reviews of their care. We did note that a record was maintained of communication with families. Visitors confirmed that staff contacted them regarding any changes to their relative's needs. A visitor said, "They ring her [next of kin] and let her know if they are bringing in a doctor."

Visitors told us that mostly they and their relatives living at the home did not know what was on the menu each day as menus were not displayed. They said sometimes the menu was written on a board in the dining but mostly it was not. They said they would like this information made available so they had an idea of what their relative was having or had had for their meals. A visitor said, "I was promised a copy of the menu but never received it."

People living at the home told us they could have visitors at any time and visitors also said staff were welcoming whenever they called. A visitor said to us, "It is 24 hour visiting."

There was a calm atmosphere in the home. Throughout the inspection we observed staff calling people by their preferred name and supporting people in an easy going and unhurried way. The staff we spoke with demonstrated a warm and genuine regard for the people living there. We observed a positive and on-going interaction between people and staff. We heard staff explaining things clearly to people in a way they understood. Personal care activities were carried out in private. People did not have to wait long if they needed support. We heard staff explaining to people what was happening prior to providing care or support. Staff spoke in an encouraging way to people who needed support at mealtimes.

We observed an altercation between two people in the dining room and noted that the staff managed this situation in a calm way, ensuring that the dignity of both people was maintained.

A key worker system was in place and the allocated keyworker list was displayed in the nurse's office. A key worker is a member of staff responsible for one or more persons. The role involves ensuring the person's support and care meets their needs.

Some of the people living at the home had no family member or friend to represent them. Staff confirmed that advocacy had not been sought for these people which meant the people did not have any independent representation regarding their care and support needs.

The dining room was not in keeping with a homely and caring environment. This was compounded by the presence of a number of staff notices on the walls and office window. The room was sparse and the dining tables were set with brown table cloths. We noted the tables at lunchtime were set with a knife and fork placed the wrong way around, which could confuse people. There were no condiments on the table.

Requires improvement

Is the service responsive?

Our findings

People and visitors said they would like more choice for meals. A visitor told us, "There is no real choice at meal times. The alternative to the main meal is either chopped pork or cheese sandwiches." A member of staff said, "I don't think it is good. I think they need two choices at meal times." From our conversations with people and visitors we concluded that people were not routinely asked in advance of each meal what they wanted but if they did not like the main meal we were told there were "pies and puddings in the freezer for those who don't like the main course".

Regarding the meals, a member of staff said, "They should have the freedom to have what they want." Menus were not displayed either in written or pictorial format. For people living with dementia this is important as it can remind them what their next meal is should they forget. We observed in the care records we looked at the people's preferences for food were recorded but the information was very minimal. We looked at the food policy and it stated, 'menus will offer a choice and service users will be asked which choice they would prefer'.

By not providing people with a reasonable choice at meal times was a breach of Regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if the care and support they received was provided in a way they liked and preferred. A person said "It depends on what it is" but was unable to elaborate further. People told us they were encouraged to do things for themselves.

We asked visitors if their relative received care that was individualised to their needs and preferences. One visitor said, "It's a routine like the hospital." Another visitor said, "I think there are elements of both. It's a balance between routine and what [relative] wants."

The care records we looked at informed us that people's needs were assessed before they were offered a place at the home. The home used a framework for care planning based on the 12 activities of daily living. We noted that people had a care plan in place for each of the activities even if they did not have a need in that area. This did not demonstrate a person-centred approach because the framework was the focus for care planning rather than each person's specific needs. We could see that the care plans were regularly reviewed and updated to reflect any changes to people's needs.

We asked people living at the home how they spent their day. People said very little happened. Mostly people said they watched television. A person said, "I sit reading and watch the television." Another person said, "It's a funny one that. There is very little to do. I'm hoping someone will come and see me. I don't know who chooses the television channel. If there was something interesting on I would watch it." A person said, "I would like to be more active."

We observed after lunch that a film was on the television. However, all the people in the lounge were asleep. One person was awake but they were looking at a newspaper.

Visitors expressed mixed views about activities. A visitor said to us, "I never see her doing anything when I visit." Another visitor said, "I'd like the staff to encourage the residents to go out more." Other visitors told us there were activities and one visitor said, "He plays games, watches videos and listens to opera."

Regarding activities, a member of staff told us, "They [people living at the home] have done cooking and done the garden. A lady comes in to do music and they do colouring in and games."

Information in the care records about people's background, relationships, working career and interests was variable. Richer information was in place for some people but was sparse for others. An activities coordinator had recently taken up post. We could see that activities were starting to happen. These included a cookery club and music afternoons. External entertainers also came to the home. The activities coordinator supported people to go out. We noted that the activities coordinator had started to record people's interests and preferences for activities. We spoke with the activities coordinator by telephone. They confirmed their aim was to develop an activity programme that took into account people's preferences. The development of the activity programme was in the early stages so it was too early to see what impact it was having.

A complaints procedure was in place. There was an audit trail in place to show how complaints had been dealt with, including a complaints log and correspondence regarding each complaint. The complaints we looked at had been resolved within a reasonable timeframe. We spoke with a

Requires improvement

Is the service responsive?

visitor who told us they had verbally complained that the television in the lounge their relative liked to sit in was too small and their relative had difficulty seeing the screen. They requested it be replaced with a bigger one but said they had not received response to this request.

When we inspected the home in July 2014 a visitor had made a similar complaint about the small size of a television and not received a response. We discussed it with the registered manager and provider at the time and we were informed after the inspection that the television had been replaced.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post as they had left the service shortly before our inspection. A new manager had been appointed and had started working at the home a week prior to this inspection. The manager told us that he was well supported by the provider who visited the home almost daily.

Prior to the inspection we had requested a Provider Information Return (PIR). A PIR 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. This had not been returned prior to the inspection.

We asked people living at the home their views of how the home was managed. People and visitors expressed mixed views about the leadership and management of the home. A person living there said, "It is well run" and a visitor said "I think it is very good. I'm pleased with it." Another visitor said, "It keeps changing. I don't know who the manager is. There is quite a turnover of managers."

We asked people and visitors how they provided feedback on the service and how they got involved in developing the service. People living at the home said they had not provided feedback on the service. A person said, "I've never been asked." Another person said, "Nobody from the home has asked me." Staff told us there had been one 'resident's meeting' in the last year. We were not provided with any information to show what had been discussed or agreed at the meeting.

The visitors we spoke with told us they had not been invited to share their views on the running of the home. We were provided with five feedback questionnaires completed in 2015. Two of the questionnaires raised concerns about food and the lack of recreational activities. There was no evidence to suggest these concerns had been followed up.

We asked staff what had been the key achievements of the service. Staff said they were pleased that an activities coordinator had been employed and recreational activities were available for people living at the home. They said it was too early to see what impact this having. A member of staff said, "They [people living at the home] have been that long without activity going on they have become set in their ways." A member of staff told us the internal decorating had been positive and they said there was further room for improvement, such as the use of colour and more homely features.

We asked staff about the key challenges the service faced. They said the layout of the building was not great for monitoring people and also for using the hoist in small rooms.

Visitors we spoke with acknowledged that recreational activities had started to happen on a regular basis. They identified other improvements the home would benefit from. They said the place seemed a bit bare and one visitor said, "It could do with a few more pictures around and more colour. The dining room could do with brightening up." Another visitor said, "The rooms could do with being more brighter."

We asked staff what support was in place for them. A member of staff said, "You've got each other and the nurses." Staff told us staff meetings were not held on a regular basis but were called when one was needed. They said there had been one in July 2015. The minutes were not available for this but we saw the minutes from the meeting held in April 2015. There was no information in place to indicate what action had been taken following the meeting after concerns had been raised. Meetings were held periodically for nursing staff.

Staff told us communication was good within the team. They said they received a handover at the changeover of shifts. A member of staff said, "We come in for handover and the girls talk [share information]". We could see what was discussed at the handover meetings as they were recorded.

Ten staff had completed feedback questionnaires over the last year. The manager was unable to provide us with information to indicate if these questionnaires had been analysed and/or responded to.

Staff predominantly undertook their training through the use of DVDs and they had raised their concerns with us about this type of training not being effective. We noted they had also raised concerns at a staff meeting in April 2015. Staff completed a knowledge based test when they had completed DVD training. We looked a range of these completed tests. Some had been assessed by the manager

and some had not. Staff told us they did not receive feedback on the outcome of their tests. This meant there was not a robust system in place to check the effectiveness of the staff training.

Staff we spoke with were aware of the whistle blowing process within the home and said they would not hesitate to report any concerns or poor practice. A member of staff said, "I'd question practice. I would feel comfortable approaching the provider."

CQC was not being informed of events as legally required. There were five people on a DoLS plan and CQC had not been notified of any of these.

We looked at the operational policies for the home and noted they were due for a review as they made reference to regulatory bodies that no longer exist and made reference to national guidance that had since been updated.

We asked to see how accidents and incidents were analysed to identify themes and patterns. We were particularly keen to see if there were any patterns in relation to the high number of incidents between people living at the home. It was not clear if they had been analysed. We asked staff how they received feedback on the outcome of concerns, such as investigations into incidents and complaints. A member of staff said, "They [management] tend to come back and tell you through the office and the nurses." Another member of staff said, "They talk it through and then go through key points, including how it can be changed." One of the staff told us the previous manager used to put a note on the wall with the outcome of incidents. None of these were available for us to look at.

We were informed by the nurse that the previous registered manager undertook regular audits and the provider undertook medication audits. We could see that care plan audits took place in March and June 2015. Some minor concerns were identified but we could not determine if these issues had been followed up. Many of the concerns found by us had not been picked up by the auditing of the service. Therefore the system in place to monitor the quality and safety of the service was not effective. There was no regard for the recommendations made in the previous inspection report. This lack of oversight put people's health safety and welfare at risk.

Not taking proper steps to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of the service was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager acknowledged that there were shortcomings with the service and had already started to assess and plan for the changes that needed to be made. For example, he showed us a file he had developed for environmental audits and advised us that this would be the basis for a new system of audit he would be introducing in the home. In addition, a staff training schedule, supervision schedule and audit programme had been developed for 2015/16. The manager spoke about the keyworker system and how relatives would be invited to get involved in the planning of care. We also noted that new files had been set up for risk assessments and audits. However, it was too early to see what impact these changes would have in 'turning the service around'.