Caram (AH) Limited

Atholl House

Inspection report

98-100 Richmond Road
Compton
Wolverhampton
West Midlands
WV3 9JJ

Tel: 01902429342
Website: www.athollhousenh.co.uk

Date of inspection visit:
18 January 2018
19 January 2018
23 January 2018

Date of publication:
13 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18, 19 and 23 January 2018 and was unannounced.

Atholl House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service provides nursing and personal care for up to 84 people. At the time of this inspection 60 people were living there, some of whom were living with dementia.

At the time of this inspection there was no registered manager. A manager had recently been appointed and we confirmed with them that they were in the process of applying to be registered with the Care Quality Commission. 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 manager was present throughout this inspection.

At the time of our last inspection undertaken on 22 and 23 September 2016 we rated the service as Requires Improvement. We found shortfalls related to staffing, risk management and quality assurance, However; no breaches of regulations were identified. At that time these topic areas were included under the key questions of safe, responsive and well-led. We reviewed and refined our assessment framework and published the new assessment framework commencing from 1 November 2017. Under the new framework these topic areas are included under the key questions of safe, effective, responsive and well-led. Therefore, for this inspection, we have inspected these key questions and also the previous key question to make sure all areas are inspected to validate the ratings.

At this inspection we saw improvements had not been made in the areas identified at our last inspection. In addition we identified a number of other concerns including breaches of regulation. These breaches include: safe care and treatment, dignity and respect, person centred care and governance.

This has resulted in the overall location being rated as requires improvement.

The provider had systems in place to monitor the quality of support given and to make changes when needed. However, these systems were ineffective and did not identify the concerns or improvements required that we found at this inspection.

The provider did not have effective infection prevention and control procedures in place. Maintenance and repair processes were ineffective and did not keep people safe from the environment within which they lived. During this inspection, pieces of equipment were removed from use as they were ineffective in keeping people safe. People's medicines were not safely stored.

People's rights were not always protected by those supporting them and the management team did not always follow the principles of the Mental Capacity Act when making decisions that effected people.

People were not always treated with dignity and their privacy and confidentiality was not respected or protected. Interactions with staff members were task focused and did not value the person as an individual. People did not have sufficient opportunity to engage in activities that they found interesting and stimulating.

Although people received care from staff that had the skills and knowledge to meet their needs they were not always treated in a kind, caring and considerate manner by those supporting them. Physical adaptations to parts of the property had not been made to enable people to safely move around their home. People did not receive information in a way they could access. The management team were unaware of the accessible information standards and had failed to implement these at Atholl House.

People received care from staff members who knew their individual likes and dislikes. However, people were not consistently involved in the creation and development of their care plans. People did not have care and support plans that reflected best practice and people's future wishes were not recorded.

People and their relatives were encouraged to raise any issues and the management team had systems in place to address such concerns or complaints. However, people did not always feel their concerns were adequately responded too. Staff members did not feel they received adequate support and guidance from the management team. Although staff felt supported by their colleagues they felt removed from decisions affecting their workplace and felt the management team did not always listen to them.

People had access to healthcare to maintain wellbeing. People were supported to eat and drink enough to maintain their health but monitoring was inaccurate and gave misleading information.

Staff attended training that was relevant to the people they supported and any additional training needed to meet people's needs was provided. People were kept safe from the potential harm of abuse or ill-treatment as staff knew how to recognise and respond to such concerns. The provider followed safe recruitment procedures when employing new staff members. Any incidents and accidents were investigated in order to minimise reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
The provider did not have effective infection prevention and control procedures in place. Maintenance and repair processes were ineffective and did not keep people safe from the environment within which they lived.
People's medicines were not safely stored.

Is the service effective?

Requires Improvement

The service was not consistently effective.
The management team failed to follow the principles of the Mental Capacity Act when making decisions for people.
The management team did not follow current guidance and best practice when supporting people.
Physical adaptations to parts of the property had not been made to enable people to safely move around their home. People received appropriate access to healthcare services when they required.

Is the service caring?

Requires Improvement

The service people received was not consistently caring.
People were not always treated with dignity and respect by those supporting them. Information confidential to people was left open in communal areas. Staff interactions with people were focused on tasks and not on valued and respectful interactions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People did not always have access to social activities that they enjoyed and found stimulating. People were not always involved in the development of their care and support plans. People received care from staff members who knew their individual likes and dislikes. People and their relatives were encouraged to raise any issues. The management team had systems in place to address any concerns or complaints but people did not always feel their concerns were adequately responded too. People did not always receive information in a way they could understand.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The provider did not have effective quality monitoring systems in place to identify improvements needed. People were asked for their views and opinions but these were not read or acted on by the management team. Staff members did not find the management team approachable and did not feel valued. When needed the manager and provider worked in collaboration with other agencies to promote continuous care and support for people. A manager was in post and was in the process of registering with the Care Quality Commission.

Atholl House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 18, 19 and 23 January 2018 and was unannounced.

This inspection was completed by four inspectors over the three days and one expert by experience on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. We looked at our own system to see if we had received any concerns or compliments about the provider. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

Before the inspection visits, 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. We used this information to help with our planning.

We asked the local authority, the clinical commissioning group and Healthwatch for any information they had which would aid our inspection. We used their feedback as part of our planning.

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 spoke with nine people, five visitors (including relatives and friends), the manager, general manager, clinical lead, the provider, three nurses, four carers, two cleaners and one cook,. We looked at the care and support plans for four people, records of quality checks, accident and incidents records, maintenance records and the medicine administration process. In addition we also looked at records relating to infection

prevention and control and details of quality checks completed by the provider. We confirmed the safe recruitment of two staff members. Following the inspection site visits the manager provided up with an update regarding the work undertaken since our visits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, completed in September 2016, we identified that improvements needed to be made in relation to risk management and staff members' understanding of risks. At this inspection we identified that improvements were still required in this area.

We asked people and their relatives whether they felt safe living at Atholl House. Those we spoke with were positive about their safety. One person said, "I have all the staff around me and they look after me." However, at this inspection we identified a number of concerns regarding people's safety.

The physical environment within which people lived at Atholl House was ineffectively maintained putting people at risk of injury or harm. One person told us, "I asked for a new light bulb and had to wait four days before this was replaced." In relation to a separate room, in another part of the building, a visitor told us that they had to replace the light bulb for their friend as it was so dull their friend had difficulty safely moving around their bedroom.

In addition to the issues raised with us by people and their visitors, we also identified a number of concerns regarding the living environment at Atholl House. For example; we saw a bathroom area with ripped floor covering which created a trip hazard and broken bath panels with jagged edges which could cause injury. This bathroom was in use on day one of this inspection but later taken out of use by the manager after we raised concerns about this area. External maintenance workers were working unsupervised in and around people's rooms. We saw tools and supplies had been left on the floor in corridors where those living with a visual impairment walked thereby creating potential trip hazards for people. A fire extinguisher was covered up by a staff members' clothing hanging off it and a fire door was wedged open preventing the self-closing mechanisms from functioning.

A number of staff members, including the management team, had passed by these hazards and no one took action to identify or rectify them until they were identified by us. However, once they were identified by us action was taken. For example; the bathroom was taken out of commission and a staff member was allocated to supervise the external work personnel. We asked the manager about these issues. They told us that the workmen should be supervised and acknowledged that they weren't. We spoke with the general manager about their policy for the use of external work personnel. After looking through the provider's policies and procedures it was discovered that they did not have such a policy.

Staff members we spoke with told us that the maintenance team worked hard to rectify repairs but owing to the size of the location found it difficult to meet the demands. Staff members said that once repairs were identified they were written in a repairs diary. However, there was little or no oversight of these repairs. For example, it was reported on 2 January 2018 that a toilet seat was missing in one communal bathroom. On 23 January 2018 we went to this bathroom, with the general manager, and saw that this toilet seat was still broken and still in use. The process for managing maintenance issues was ineffective and this put people at risk of harm. There were two additional communal toilets in this area. One had been taken out of use on day one of this inspection site visit and the other had a sign on it saying out of order owing to a broken door

handle. Following our inspection site visit the manager contacted us to say they had introduced a new system for identifying any repairs that had not been corrected. However, we were not able to confirm the effectiveness of this system as it was introduced following our visits.

People were at risk as the infection prevention and control systems in place at Atholl House were ineffective. For example; we saw ripped flooring which prevented the effective cleaning in communal areas, used incontinence pads were left in the sink of a communal bathroom and a lift used, by people who used the service and staff, as access between floors was dirty and contained broken glass and ripped cardboard. One staff member told us, "We did have an infection prevention and control lead person but we don't now. We don't understand what happened with this role." We saw a fridge that was in use in one communal area and contained perishable food items. The door of this fridge was rusty preventing effective cleaning. The internal temperature of the fridge indicated that it was "too hot" on five occasions out of six throughout this inspection. We identified this to the manager who told us, "We will get a replacement." The general manager told us checks to the fridges were done as part of the general quality checks completed by the kitchen staff. However; there was little or no oversight to ensure these checks were effective in identifying or responding to concerns which put people at risk. Following the inspection visit the manager contacted us informing us that a replacement fridge had been provided for storing perishable food items in the communal dining area.

People provided us with mixed responses when we asked about them receiving their medicines safely. One person said, "The staff make sure I take my medication." Another person told us about a recent incident where they had to question the medicine that the staff members had provided them. They were told that the medicine was correct and that they were wrong to question it. However, a short time later the staff member returned with the additional medicine that was missing. This person told us, "I knew I did not have the right medicine and they (staff) just dismissed it and didn't like me questioning them about it."

The clinical lead showed us the storage areas where people's medicines were kept. We looked at one fridge where temperature sensitive medicines were stored. Staff members kept a daily record of the fridge temperature. We looked at this record and saw there was an instruction to report any temperature which was outside of a defined range. We identified that in the last month the temperature was too low for the medicines stored in it on 14 occasions. We asked the clinical lead to take action on this and seek professional advice. They later told us that the medicines had been compromised and therefore needed to be destroyed and reordered. This lack of effective monitoring and oversight put people at risk of receiving medicines which had their integrity compromised and was unsafe. Following the inspection site visit the manager informed us that a replacement refrigerated storage area was purchased.

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

People and staff members expressed differing opinions when we asked them if there were enough staff to safely meet their needs. One person replied, "Yes definitely. They come quickly when I press the buzzer, 24hr care. I am very happy." Another person said, "There are not enough helpers and qualified Nurses." Another person told us, "They never have enough time to do things, but it is not their fault, they could do with one or two more staff," One person went on to tell us, "There is a problem. The management seems to forget that everybody on this floor needs 2 carers to hoist them. They took some staff away and put them upstairs. There is not enough." One staff member said, "Recently we have lost one nurse from shifts. The management never gave us a rationale for this. We now have two nurses working over three floors and I don't feel that this is safe for anyone." The manager told us that changes in the way people worked had been introduced at Atholl House. This has included the training of carers to assist qualified nurses with

people's medicines.

We looked at how people were kept safe from the risks of harm associated with receiving care. Generally people we spoke with told us they felt safe receiving care and support whilst at Atholl House. One relative said "[Relative's name] is safe and has a special bed and a hoist. Two helpers are required every time they need help." We saw risk assessments in place for skin integrity, moving and handling and falls prevention. At this inspection we saw staff safely supported people with the use of equipment such as hoists. However, during the time we spent in one lounge area one person constantly kept standing and reaching for something that was out of their reach. There was no staff member available in this area for a recorded period of time of 25 minutes. When a staff member arrived into this room they said "sit down or else you will fall." Staff members were able to identify risks but were not always present to prevent risky situations from occurring in the first instance. Despite the assessments of risk being in place the deployment of staff on shift throughout Atholl House did not promote a safe environment for those living there.

People had personal emergency evacuation assessments in place which details their level of need and the support that they would require in an emergency such as a fire.

Incident, accidents and near misses were recorded and monitored by the management team in order to identify any further actions that may be required to prevent reoccurrence. One person told us about a recent fall. They went on to say this was as a result of pushing too hard on a door which they then fell through. They told us they received treatment promptly and an adaptation was later made to the door to help prevent this from occurring again.

The equipment that people used to assist them was maintained and kept in working order. The management team had systems in place to ensure the equipment which people used was safe and met their needs. For example, we saw that equipment such as hoists and stand aids were regularly serviced to ensure safe working order.

We looked at how people were kept safe from the risks of abuse. People we spoke with told us they believed they were protected and safe. One person said, "If I was worried I could talk to anyone." Others we spoke with told us they would contact the manager should they need to do so. One staff member said, "I have completed my training and if I had any fears I would go to [manager's name] or report it to the CQC". We saw information was available to people, staff and visitors informing them how to report any concerns. We saw that the provider had made appropriate notifications to the local authority in order to keep people safe.

Staff members told us that before they were allowed to start work checks were completed to ensure they were safe to work with people. Staff told us references and checks with the Disclosure and Barring Service (DBS) were completed and once the provider was satisfied with the responses they could start work. The (DBS) helps employers make safer recruitment decisions and prevent unsuitable staff from working with people. The provider had systems in place to address any unsafe behaviour displayed by staff members which included disciplinary action if required.

Requires Improvement

Is the service effective?

Our findings

We looked at how people's rights were protected at Atholl House. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and identified they were not.

We saw people's capacity to make decisions regarding their personal care and daily living activities was assessed and reviewed when needed. However, the management team did not follow these arrangements in all instances. For example, a number of changes to the layout of Atholl House have been implemented. This has involved a number of people moving rooms to meet the changing needs of the location. However, no specific capacity assessments had been completed regarding people's decisions to move to other parts of the building. No best interest decisions had been made to indicate that these moves were for the benefit of those affected. We asked the management team about this and they informed us that did not believe it was needed in these instances which demonstrated a lack of awareness and application of these decision making principles.

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 saw the provider had made appropriate applications and they had systems in place to make renewed applications if needed.

People and relatives we spoke with gave us conflicting information on the skills of the staff members supporting them. A couple of people we spoke with were clear with us that the staff supporting them were skilled to effectively meet their needs. However, one person told us, "They are still learning and certain staff can't do basic tasks. There is no conversation." New staff members working at Atholl House undertook an introduction to their role which included, as part of their basic training, fire regulations and safety, and working alongside other staff members. One staff member told us, "At the end of the induction I was asked how I was getting on and if I needed any extra time. I didn't feel rushed to do something I didn't."

Staff we spoke with had access to training to enable them to support people. For example, one staff member told us they were completing their medicine practitioner training. This is training provided to care staff members, who are not nurses, to enable them to support people with certain medicines. One staff member said, "This is very interesting training and I am glad I am doing it. However, I would like further training to give me the knowledge of the different types of medicines and the effect they have on the person. This would help me to give information to people about what they are taking and their effects." Another staff member told us they had recently completed dysphagia training. The staff member said, "The dysphagia training helped me to support those with swallowing difficulties and in making sure they got the correct food." The qualified nurses we spoke with felt supported to maintain their registration with the Nursing and Midwifery Council as part of the re-validation process.

Staff members we spoke with told us they felt valued and supported by their colleagues but not by the management team. One staff member said, "I have had a yearly appraisal but I can't recall when I had a supervision (one-on-one support session with a senior). I would rather go to my co-workers rather than go to the management team with anything." Another staff member said, "We know we should be doing supervisions but they are just not happening because no one has the time." Staff members we spoke with did not feel that they received effective support from the management team. We spoke to the manager about the effective support of those working at Atholl House. They told us that it was their intention to reintroduce structured supervision and support sessions for all staff members. They went on to say that this would be introduced over the next few months.

People were supported to have enough to eat and drink and to maintain a healthy diet. We saw people making choices of what to eat and where they would like to have their meals. When people did not want what was on the menu they had alternatives available to them. We asked people about the food they ate at Atholl House. One person said it was, "OK," and another said it was, "Good." All those we spoke with told us they were asked what they would like to eat and this was provided. We saw staff members supporting people at a pace to suit their personal needs. When people took their time to eat their food we saw staff members asking if they would like it reheated.

When required people had their food and fluid intake monitored to see if any additional intervention was required. For example; when it was needed a referral to a dietician was completed. We looked at one person's fluid recordings. The manager told us the purpose of this recording was to get a "base line" for fluid intake over a five day period and this will be a target for their intake. However, on examination with the manager, and when cross referencing with daily records we identified only four recordings were made two of which were inaccurate. This meant the "baseline" record was inaccurate and incomplete. There was a lack of managerial and clinical oversight which should have identified and corrected these errors to ensure the person received the correct intervention when they required it.

The physical environment within which people lived at Atholl House Nursing Home was over three floors with stairs and lift access. People, and their visitors, had access to private and confidential space should they wish. There was also the opportunity for people so spend time in communal areas where they could socialise with others. There were outside areas for people to spend time in, if they wanted, but owing to the time of year and weather conditions people were not using these areas.

One person told us about the difficulty that they had when moving around Atholl House. They said they had a visual impairment and the slope in one of the corridors was unsafe and unnerving for them. They told us they have stumbled on at least two occasions owing to the fact that the slope is not clearly defined and there are no hand rails to support them when independently moving. We saw hand rails were present in other areas of Atholl House but not where this slope was and not where the person perceived the danger to be. We asked the management team about the lack of physical adaptation in this area. The manager said, "This is something we can look at." The lack of managerial oversight has resulted in such areas of concern not being identified or corrected to effectively meet people's needs. Following the inspection site visit the manager contacted us to say that the necessary hand rails are due to be fitted and a date identified for the work to be completed.

People had access to other healthcare professionals and services when they required it. One person said, "I get to see a doctor whenever I need one. They (staff) are very prompt in seeking guidance from them when they are not sure about something." We saw people had access to GPs dieticians and foot health professionals when needed.

We saw staff members passing on information regarding the health and welfare of people living at Atholl House. For example, we saw staff members talking with visiting healthcare professionals and updating them on those they were seeing. This was to enable the visiting professional to make a more informed decision about those they were supporting.

Requires Improvement

Is the service caring?

Our findings

At this inspection we found that not all staff were consistently caring in their approach to those they supported. We saw differing experiences between how people were treated by those supporting them. Those we spoke with described staff with mixed feelings. People and visitors described staff as, "Encouraging" and "Helpful." However others told us staff members appeared rushed and non-communicative. One person said, "They listen, when I make them." One visitor told us, "They (staff) seem to talk to many residents, including my relative. I find them both professional and polite. They are very approachable." Other visitors described staff as, "Polite, approachable and lovely."

One person told us about having to keep their bedroom door open at all times including when they slept and when completing their own personal care. This compromised their privacy and dignity and we saw made them anxious on a number of occasions. Staff were not always available to support them at these times. We spoke with the manager about this with the person's permission and with them present. The manager asked the person, "Is it your choice to leave the door open?" To which the person replied, "Yes." However, staff members had failed to spend time with this person to explore the reasons for their decision. The person told us they had a fear of the door closure mechanism and told us about a time when they pulled the door shut. They said the clasp swung towards the person. They described it as, "Nearly taking my head off." The general manager told us that alternatives had now been identified and will be discussed with the person to help promote their dignity and sense of safety and reassurance.

People gave us differing views about how their privacy and dignity was maintained and whether they were treated with respect at Atholl House. One person said, "Staff always knock and ask if it is alright to come in." Another person said, "They (staff) always make sure I am covered up when doing personal care." However, we were also told, and we saw, instances where people's dignity had been compromised. One visitor told us that there had not been any hot water in their friend's room for a prolonged period of time. They said, "[Person's name] likes a wet shave. No staff member thought about giving them a bowl with water so they could do this. I gave them a bowl and razor and this stayed in their room for three days without a staff member removing it. On one occasion they used the toilet but there was no toilet roll or hot water with which to wash. Dignity is a simple but important thing." We raised the issue regarding the lack of hot water with the management team on day one of the Inspection site visit and this was corrected when we were present on day two.

During our observations we saw staff members supported people promptly but throughout this inspection interaction with people was very task focused. For example, during one 40 minute observation there was no social interaction between staff members and those sitting in one of the lounges other that assisting people to the toilet and with a drink. One staff member said, "We just don't have time to sit and talk with people. We are always moving onto the next thing that needs to be done." Although there were enough staff available to meet people's needs these staff members were rushed and did not have time to spend with people in a way they felt valued.
One person told us about a recent confrontation that they had had with two staff members regarding their medicines. This person believed the staff members had omitted something which they should have

provided. They told us they had informed the staff members that they had made a mistake and the staff members "Had a go at me." This person went on and said, "I felt patronised and belittled by them. It shouldn't have happened. I should feel safe and able to raise a concern with them." The person went on to say that action had been taken against one staff member but not the other. They did not know why as both had acted in a disrespectful way to them. We spoke with the manager about this and they clarified this was accurate but was not clear why action was only taken regarding one staff member. In this instance staff interactions fell below the expected standard of those supporting people at Atholl House. People did not consistently feel as if they mattered to those supporting them and that staff did not always listen to them and talk with them appropriately. Following this inspection's site visits the manager told us action had now been taken in respect of both staff members.

Information personal and confidential to people was not stored appropriately and left unsecure. For example, on day one of the inspection site visit we sat at a dining table in a communal area accessible to people, visitors and any relatives. On the table was a list of people's names, their rooms and notes about their personal care. On day three of the inspection in the ground floor nurses' station we saw people's confidential personal files were left open and accessible to anyone passing that area. These files contained details of the person, their individual needs and medical diagnosis. We asked the clinical lead about these. They told us, "We should find a way to lock these out of sight but to make them also accessible to care staff." This lack of managerial oversight compromised individual's right to confidentiality.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were involved in making decisions about their care and whether they were involved in planning their support. Again we received mixed opinions from people regarding this. During the observations we carried out we saw that there was a passive agreement to tasks and personal care. This meant that people did not object to staff members supporting them. However, the staff members did not seek direct permission from the person they were assisting at that time. One person told us about adaptation made to their room. This person spent prolonged periods of time in their bed and enjoyed looking out of their window. However, the management team took the decision to have frosted glass covering placed over the bottom half of their window preventing a clear view outside. We spoke with the person who then told us they complained about this and the frosting had been removed but then replaced with a net curtain which still prevented their view. We asked the manager about this and they instructed us this was out of concerns for the privacy of the person as those outside could look in. From our discussions with this person it was evident they could make this decision for themselves. However, others had made the decision to restrict their view. The person was then reliant on staff members to open the net curtains for them.

We observed staff interacted with people in a task focussed way based on their basic needs with little focus on emotional support. For example; during one period of observation in a communal lounge we saw 12 interactions between staff members and those sitting in the lounge. All of these interactions were focused on either supporting someone to the toilet or on two occasions to support someone with their food. Outside of these tasks we did not see any focus on conversation or interaction which valued the person as an individual.

On several occasions we saw staff members coming into the room and assisting people to move to other areas of Atholl House using various pieces of equipment such as hoists and wheelchairs. All the interactions were pleasant and polite and the information was given to people about what was happening. However, we

did not see any interaction where the staff member asked the person if it was alright to support, move them or at times if the person, for instance, actually needed the toilet, which was where staff were taking them.

We also noted some positive interactions between people and staff. We saw one person chatting with a staff member in their bedroom. This person described this staff member as, "An angel, lovely and there for a chat if I need it." This staff member was not part of the direct care staff and had opportunity to spend time with people.

People told us they were encouraged to be as independent as they were able. At this inspection we saw some people moving around as much as they wanted or were able. We saw that when needed they were supported with individual mobility equipment. However, free movement and independence was hampered by the lack of physical adaption to certain areas within Atholl House, for example missing hand rails on slopped corridors.

People, friends and family told us visitors were able to come and see them when they wanted and private areas were available. We saw people visiting and spending time with people in communal areas and in their rooms. One relative told us, "Visiting is completely open and we can visit whenever we want. We are always welcome."

Requires Improvement

Is the service responsive?

Our findings

People told us about differing experiences regarding their care and support planning. Some reported being involved in decisions about the care they received whilst others were not. One relative said, "[Relative's name] had been involved in the pre-admission assessment and in devising the care plan." One person said, "I haven't seen it." Another person told us, "I don't know what it is." One visitor said, "It is not person centred care here."

We looked at people's care and support plans. Those we looked at gave us key information about the person and how they were to be supported. For example, we saw one person was at risk of developing complications regarding their skin integrity and how staff members were to support the person. Other care and support plans informed staff members on how to support people in relation to their health such as managing epilepsy, nutrition and wound management.

However, people's future wishes had not been identified or recorded. We saw a number of documents in people's files which prompted staff members to have conversations and record people's wishes for their future care and support. These documents were advanced care plans and, at this inspection, none had been completed and all that we looked at were blank. We asked staff and the management team if these wishes were recorded elsewhere but they were not.

We identified one person who was approaching end of life. We were aware that a local palliative care organisation had visited and advised staff members so we asked to look at the person's care and support plan. We were informed by the clinical lead that the nurse responsible for the care plan was waiting for the GP to sign it. Five days after the professionals visit we looked at this end of life plan. It did not contain any information which would direct staff members on how to support this person. For example; the person's spiritual needs and preferences had not been recorded. Relevant sections were left blank and despite the opportunity to talk to this person and their family there were no records of any conversations. The manager told us they had spoken with family members about the person's wishes. However, they went on to say that they had failed to record this anywhere in the person's care or support plan. This resulted in the staff team not knowing the persons wishes' or any family anxieties, meaning they could not effectively support them as they approached end of life. Following this inspection's site visits the manager contacted us informing that this person's end of life care plan had been completed.

One visitor told us about the person they had visited. They said that this person's personal appearance mattered to them. However; when they arrived recently they still did not have their teeth in at 11:30. The visitor assisted the person with their teeth as they knew they would be upset without them. People did not always receive care and support that was personal to them and centered on their personal needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members we spoke with were aware of people's individual needs and preferences which informed their

care and support. For example, staff members could tell us what individual's religious and faith practices were and how they supported them. One staff member told us about one person's faith and how at times they indicated opinions and wishes not in accordance with their faith. The staff member said, "At these times we just have a chat and ask how this would impact on their faith. They can decide what they want to do but sometimes just talking with someone allows them to make a more informed decision." Another staff member said, "We (staff) have been here for a long time. A lot of us have been here for years. It is over this period of time that we get to know the people we support.

Staff members and the management team did not always seek alternative ways to communicate with people in order to reduce or remove barriers. For example, one person who was registered blind did not have any information regarding their care and support whilst living at Atholl House in a way that suited their needs. One visitor told us, "[Person's name] is partially deaf. Staff do not give them time to process information, or tailor their communication to make sure they had heard, and understood. [Person's name] has capacity and is able to make decisions about their day-to-day care." We saw a staff member come into this person's room. The staff member spoke with this person very quickly and did not allow time for them to understand and respond to what had been said to them.

All providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard. This means that services must identify, record, flag, share and meet people's information and communication needs. At this inspection Atholl House was supporting people who were registered blind, deaf and who had a diagnosed learning disability. No information had been recorded on how to support these people to access information relating to them and their care. For example one person with a visual impairment did not have any large font information available to them. The person with a hearing impairment did not have specific communication styles recorded for staff members to follow. We asked the manager and general manager about these standards. Neither of those we spoke with were aware of these standards. As a result the management team had failed to identify people's information and communication needs in line with these standards.

Staff followed current guidance regarding do not attempt cardiopulmonary resuscitation (DNACPR). People's views and the opinions of those that mattered to them were recorded. Decisions were clearly displayed in people's personal files.

We asked people about their personal interests, hobbies and things they were interested in. We received mixed responses from people. One person said, "I read a lot, play chess and do crosswords". Another person said, "There are a lot of activities. They played bingo this morning and there are trips out." Throughout this inspection we saw a number of activities taking place with people. These included baking sessions, crafts and one-on-one time with the activities staff. However; people also told us they got bored. People and visitors told us weekends appeared to be a time where there was little in the way of activities for people to engage in.

We spoke to the manager about encouraging people's involvement in following their interests when the activity workers were not present at Atholl house. They told us that every Saturday someone came in to complete a movement with music exercise session but at present this was the only structured activity at weekends. The manager acknowledged there was a lack of activities for people to engage with during the weekend. They went on to say that they are looking at the deployment of staff to try and improve on these activities during this time.

People, families and visitors we spoke with told us they were aware of how to raise a complaint should they wish to do so. One person told us they had raised a complaint after feeling cold in their room and the

radiator was altered which they were happy with. Another person said that after raising a complaint the management apologised and informed them that the staff member concerned would also be making an apology to them. At this inspection site visit this person said, "I don't know what has happened but I am still waiting for the apology. It isn't a big thing but just an acknowledgement of how I felt would mean a lot." We spoke to the manager about this and they informed us that they were looking at additional action they may take in this instance. One visitor told us that the manager was receptive to complaints made and that they tried to resolve them to the best of their ability.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we identified that improvements were needed to be made in relation to the systems in place for monitoring the quality of service provided at Atholl House. At this inspection we found improvements had not been made and we identified additional concerns regarding the overall quality of people's experience.

The provider's internal quality monitoring of services at Atholl House was not effective in identifying shortfalls regarding people's care and the environment in which they live. This included issues related to the safety and cleanliness of the living environment, the management of medicines, privacy and dignity, person centred care and how people's consent was sought.

The provider carried out a 'resident and relative's satisfaction survey' during 2017. However, we looked at the results of this survey and asked the management team what action had been completed as a result. The manager confirmed with us that they had not gone through this survey. They had not identified whether the feedback was positive or negative or whether any action was needed as a result of this feedback. Therefor no action had been taken by the management team or the provider following this survey. Although this survey was completed when the preceding manager was in post, action had yet to be taken. The manager told us it was their intention to review the way they encouraged feedback. One person told us, "I would welcome the opportunity to be more involved in the home and to give more constructive feedback if it meant that we could change things." We passed this onto the management team, with the person's permission, and the general manager told us that this is something they will consider.

These concerns form a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised the issues, identified during the inspection site visits, with the management team. When informed they took action to correct some of the concerns immediately. For example, we saw broken door handles were replaced during day two of the site visit. Following the inspection site visits we received a report from the manager telling us what additional action had been taken and what was still to be achieved. For example, they informed us the medicine storage fridge had been replaced and a date for the corridor hand rails had been identified.

The provider had appointed a new manager at Atholl House Nursing Home in November 2017. Although they were yet to register with the Care Quality Commission we saw confirmation that they had made the initial application to become a registered manager. The manager was supported in their role by a general manager and a clinical lead.

The manager understood the requirements of their registration with the Care Quality Commission should their application be successful. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. We received notifications as required. We saw that the provider had, within the home, displayed its rating from our last previous inspection at Atholl

House and also on their website.

People we spoke with told us they knew who the manager was and that they saw them on a regular basis. People described them as "good" and one visitor went on to say, "[Manager's name] has been helpful and sorted out a new room (owing to concerns), but I hate to think what would have happened if I was not here to stand up for [person's name]. It also makes me wonder about those living here who have no one to fight their corner."

Staff we spoke with told us they did not know who the manager was when they first started. One staff member said, "It was all very strange. They just turned up and we did not know who they were. They did not introduce themselves and after about two weeks we were told they were the new manager. Some of us thought they were a director or something". We asked the manager about this and they told us owing to the anticipated changes to the management structure at the time staff were not made aware as the final decision had not been made.

Staff members went on to say that communication was lacking and they didn't know what was happening with some of the changes at Atholl House. For example, one staff member told us, "We had a change of the medicine system. No one told us why the last system was no good." Another staff member said, "We have just lost a nurse on shift. The reasons we were given do not make any sense to us at all. We are all pushed and this just adds to our stress." Staff members told us they did not understand or feel a part of the changes at Atholl House. One staff member said, "We should not be changing everyone around and redesigning parts of the building when we can't even have door handles on doors replaced."

Staff members told us that they relied on their colleagues for information about changes but recognised that this was an ineffective system for cascading important information. One staff member said, "We are not having the staff meetings we should. We had one but we were talked at rather than involved in it." We saw information on notice boards explaining some of the changes at Atholl House but the staff we spoke with felt de-moralised and not involved with the decision making processes. One staff member told us, "If I understood what was happening I could tell those living here."

We saw that some people and relatives had attended a meeting with the management team. It was during one of these meeting that the changes to Atholl House were explained to them. We saw details of this meeting on display in communal areas for the information of those who were unable to attend. However, none of those we spoke with told us they were involved or informed about the changes at Atholl House.

We asked the manager what it was they felt Atholl House did well. They informed us they believed they were very good at telling people how much it would cost to live at Atholl House and they provided us with literature explaining the services offered. However; this information was not in an accessible format which others could use and understand.

The provider had systems in place to address any unsafe behaviour displayed by staff members which included disciplinary action or re-training if required. Staff members were aware of appropriate policies which directed their practice including the provider's whistleblowing policy. However, staff members we spoke with were unsure what action would be taken as a result of using this process or if they would be supported by the management team.

Although the management team had policies and processes in place to support and guide staff they had not been reviewed to ensure they met the needs of those living at Atholl House. For instance there was no policy regarding external work personnel.

We saw details of partnership working with other key agencies involved in the support of people. These included the local authority, GP's, Tissue Viability Nurses and foot care practitioners.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support that was based on their personal needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Information confidential to them was not stored securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored safely. The maintenance where people lived was not completed effectively. The provider did not promote safe infection prevention and control procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality monitoring systems in place to identify and drive good practice. This was the second consecutive requires improvement rated inspection.