Lavender Lodge Limited

Lavender Lodge Nursing Home

Inspection report

40-50 Stafford Street
Derby
Derbyshire
DE1 1JL

Tel: 01332298388

Date of inspection visit:
26 July 2018

Date of publication:
11 October 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Lavender Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lavender Lodge Nursing Home is a care and nursing home in the city centre of Derby. It has 44 beds and specialises in catering for older people, some of whom are living with dementia or a physical disability. On the day of our inspection there were 42 people living at the home.

At our last inspection of this home on 17 and 18 January 2018 we found two breaches of the regulations because the home was not always safe or well-led. We issued a requirement notice and a warning notice in response to these. Following our inspection the provider submitted an action plan stating how they intended to achieve compliance.

At this inspection we found that although some improvements had been made the home was still not fully compliant with the regulations.

The service had a registered manager. 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.

We found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. Although some audits had been put in place these were not always effective. There was no comprehensive audit or other monitoring system in place to ensure quality performance, risks and regulatory requirements were understood and managed.

We also found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Safe care and treatment. This was because improvements were needed to the way medicines were managed to ensure they were administered safely.

People were assessed prior to them moving into the home to ensure the staff could meet their needs. Risks to people were assessed and their safety monitored. Staff had been trained in moving and handling and new, safer wheelchairs purchased.

Staff recruitment files were missing some essential documentation to show people were suitable to work in care. Most staff had completed all their essential training courses and those that hadn't were booked to attend forthcoming courses.

People medical needs were met and a GP visited the home weekly to provide a surgery. One person's

medical records needed improvement.
Staff understood their responsibilities with regard to the Mental Capacity Act 2005 (MCA) and sought people's consent before providing them with care and support.

Improvements were needed to the adaptation, design and decoration of the premises to ensure people's individual needs were met, particularly the needs of people living with dementia. The home was clean and tidy on the day of our inspection. There was an abundance of flowers in the garden and courtyard areas which people and relatives commented positively on.

People were supported to eat and drink enough and maintain a balanced diet. Staff knew people's dietary preferences. If people needed one-to-one assistance with their meals this was provided. People were encouraged to choose what they ate. The food was well-presented, nutritious and varied. People's cultural dietary needs were considered when meals were planned. English, Russia and Polish dishes were served.

People and relatives told us they were satisfied with the service provided at the home. The provider had carried out a survey of people's and relatives' views and organised coffee morning with a view to involving them in the running of the home.

We saw that relationships between people and staff were good and staff interacted with people at every opportunity. The staff were kind and caring. They supported people to express their views and be actively involved in making decisions about their daily lives and how they wanted to be supported. Care plans had been made more personalised and included details about people's preferences and cultural needs.

The home's part time activity coordinator, ran a music session during our inspection. This was hugely successful with people enjoying the music and the physical activity that went with it. Some people said they would like more activities at the home and the opportunity to get out into the wider community.

The provider's complaints procedure needed amending to make it clear that it is the local authority, not CQC, who is responsible for investigating complaints. The acting manager said this issue would be addressed.

At the time of our inspection the provider was working with the local authority and the health service to address some of the issues at the home with a view to improving the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

This service was not consistently safe.

Medicines were not always managed safely.

Improvements had been made to the way risks to people were assessed.

Staff knew how to keep people safe and report any concerns they might have about their well-being them.

Staff recruitment processes were not always followed.

The premises were clean and hygienic.

Further action was needed to ensure lessons were learnt from accidents and incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were assessed and met by staff who were skilled. Most staff had completed the training they needed to provide effective care.

People were supported to maintain their health and well-being, and, where required, with their meals and drinks.

Improvements were needed to the premises to make them more suitable to people's individual needs.

Staff understood the principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline their care.

Is the service caring?

Good

The service was caring.

The staff were kind and caring and had good relationships with the people they supported.

If people needed reassurance staff provided this in a sensitive and compassionate manner.

Staff supported people to make choices. People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Care plans were personalised and included information about people's preferences and cultural needs.

Some high-quality activities were provided.

The provider's complaints procedure needed updating.

An improvement was needed to one person's end of their life care plan.

Is the service well-led?

Requires Improvement

This service was not consistently well-led

Quality performance, risks and regulatory requirements had not been effectively managed.

Some audits had been completed to review the quality of care provided but these had not always identified shortfalls at the home.

People and relatives had the opportunity to provide feedback on the service.

Lavender 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 was an unannounced comprehensive inspection, which took place on 26 July 2018.

The inspection team consisted of an inspector, an assistant inspector, a specialist advisor, and an expert by experience. A specialist advisor is a person with professional expertise in care and/or nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion, we had not asked the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us. We also looked at the action plan the provider sent us following our previous inspection.

We looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

During this inspection, we spoke with six people and two relatives and spent time observing the people

living in the home to help us understand the experience of people who could not talk to us. We spoke with an external staff trainer. We also spoke with the provider, who is also the registered manager. They were on site for some of the inspection but left before we fed back on what we had found. We also spoke with one of the directors, the acting manager, two nurses, two care workers, the activities coordinator, and the cook.

We looked at records relating to all aspects of the home including staffing, medicines, accidents and incidents, and quality assurance. We also looked at four people's care records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the provider had failed to comply with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. This was because risk assessments to promote people's safety were not properly calculated or detailed enough, some staff moving and handling practice did not keep people safe, and medicine was not always safely provided to people. In addition, lessons had not always been learned from past safety incidents and people had not been comprehensively protected from the risk of injury or the risk from infection.

At this inspection we found that although there were some improvements the provider was still not compliant with this regulation.

Medicines had not always been stored at the correct temperatures which may have compromised how effective they were. On the day of our inspection we found medicines that should have been stored at 'room temperature' (15 to 25 C) were stored at 27 C in the medicines storage room. Staff had monitored the storage room temperatures but the records for July 2018 showed gaps in recordings.

Medicines kept in trolleys, for more immediate use, had also been kept at too high a temperature. Records for July 2018 showed occasions where the temperature had reached 26 C and there was again a gap in recordings.

The temperature for refrigerated medicines, that should be kept at between 2 to 8 C, had also exceeded this level. Records showed that on three occasions in July 2018 temperatures had reached 9C in the refrigerator.

The provider had purchased some fans to reduce temperatures in storage areas although only one of these was in use.

Other improvements were needed to medicines management systems. One person's eye drops were out of date. The lid on the sharps box was not securely attached and the box had not been dated on construction. One person had no PRN (as required) protocol for an anti-anxiety medicine explaining when it should be given. Another person had a PRN protocol for anti-anxiety medicine they had not been prescribed. One person was receiving pain relieving medication via a trans-dermal patch. However, the chart showing the administration site was not consistently completed so we could not be sure it had been correctly applied and the previous patch removed. Another person taking insulin did not have a chart indicating the injection site. These charts are used to prevent over use of the same site.

Records did not show how staff assessed pain when people were prescribed PRN (as required) pain relief so it was not clear when this should be given. This was of concern, particularly regarding people living with dementia or other cognitive difficulties who may not be able to say when they are in pain.

Hand written prescriptions were not always signed by two staff as recommended by NICE (National Institute for Clinical Excellence) guidance.

Some people were prescribed proton pump inhibitors that need to be given 30 to 60 minutes before food and other medication to ensure their effectiveness. However, the provider did not have consistent arrangements in place to ensure these specific administration instructions were followed. Records to show prescribed topical creams being applied as required were incomplete so we could not be sure these creams were applied as prescribed.

We looked at records for four people who were being given their medicines covertly. Documentation was not always in place to support this or evidence that a best interest's meetings had been held. Staff had not always sought advice from a pharmacist as to whether the covert medicines were being supplied in a form that was suited to covert administration, nor whether there were any contra-indications regarding what food or drink the medicines could be given with. The care plans for giving covert medicines did not state the safeguards that need to be in place to ensure all the medication is taken by the person it is intended for.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Safe care and treatment. Medicines were not always safely managed.

We saw some good medicines practice. At the front of people's medicines records there was a current photograph, allergy information, and details of how the person liked to be supported to take their medicines. Staff had access to up to date information and resources on medicines including their use, side effects and contra-indications. We observed part of the medicines round. This was carried out safely and in personalised an unhurried way with each person being told what their medicines were for.

Some improvements had been made to the way risks to people were assessed and their safety monitored. Each person had risk assessments for four key areas: falls; nutrition; tissue viability; and moving and handling, and these were reviewed monthly. They then had additional risk assessments depending on their needs, for example people who smoked had a risk assessment for this. This meant staff had the information they needed to support people safely.

For example, one person whose behaviour could challenge others had a detailed care plan for this. Staff were told to discreetly observe the person and distract them away from others if necessary. They also had a sensor by their bed at night so staff could support them if they got up and they always had two staff supporting them if they were receiving personal care. This showed that staff were keeping this person and others safe and at the same time using the least restrictive practice to, as far as possible, protect the person's freedom of movement.

At our last inspection we found that people were not always assisted to move in a safe way due to unsafe moving and handling techniques and wheelchairs with missing footplates. At this inspection staff had been re-trained in moving and handling and new wheelchairs with footplates purchased. We observed staff assisting people to move in a safe and caring way and ensuring people put their feet on wheelchair footplates when they were using them.

The home had a number of cats which staff told us were popular with the people living there. However, bowls of cat food and water had been left in areas that people had access to. This could potentially cause a tripping or slipping hazard or an issue with some of people having access to cat food. The acting manager said they would review this situation with a view to ensuring the bowls were not a hazard.

People told us they felt safe living at the home. One person said, "I feel safe here, if it wasn't for them [the staff] I wouldn't be here." A relative said they were happy their family member was living at the home because it was secure. Staff were trained in safeguarding and knew what to do if they were concerned about

the well-being of any of the people using the service.

All the people and relatives we spoke with said they thought there were enough staff employed to meet people's needs. One person said, "There's definitely enough staff, there's always staff in the communal rooms." During our inspection we saw that staff were prompt to assist people and people received prompt assistance when they needed support.

Some improvements were needed to staff recruitment files. Photocopied ID documents were not signed and dated when the photocopies were taken so we could not be sure how current they were. People's reference history was not always complete. For instance, one care worker's references were from a previous, but not most recent, employer and supplied by staff who had retired. Some staff member's DBS records did not clearly show the level of DBS check they had had. The acting manager said all staff recruitment files would be reviewed and improvements made where necessary.

Some improvements were needed to staff recruitment files. Photocopied ID documents were not signed and dated when the photocopies were taken so we could not be sure how current they were. People's reference history was not always complete. For instance, one care worker's references were from a previous, but not most recent, employer and supplied by staff who had retired. (Following our inspection the provider said this was because their previous employer did not as a matter of practice provide references other than to confirm staff had worked for them.) Some staff member's DBS records did not clearly show the level of DBS check they had had. The acting manager said all staff recruitment files would be reviewed and improvements made where necessary.

People and relatives said they were satisfied with the cleanliness of the home. On the day of our inspection all areas we saw were clean and tidy. Domestic staff had access to a good range of cleaning products which were kept securely. Staff were trained in infection control and used gloves and aprons when providing personal care.

The acting manager told us that they were in the process of reviewing and improving infection control at the home. They said they had appointed an infection control lead and were working with them to ensure thorough cleaning schedules were in place to ensure the standard of cleanliness was good.

We looked at whether lessons had been learned and improvements made when things had gone wrong. Records showed that in May 2018 a person had left the home unaccompanied when it was not safe for them to do so. To prevent a recurrence the fencing was improved to make the premises more secure.

However, other incidents had not always resulted in improvements being made. Records showed that several people had fallen at the home between April and July 2018. Although in each case the person was uninjured the 'What did we do' sections of the forms were lacking in detail and it was unclear what was being done to prevent the incidents happening again. The acting manager said this would be addressed.

Requires Improvement

Is the service effective?

Our findings

People were assessed prior to moving into the home to ensure the staff could meet their care and, where applicable, nursing needs. Assessments were carried out in conjunction with people themselves, their families, and any health and social care professionals involved in their care and support. People's cultural needs were identified as part of their pre-admission assessment. For example, one person was assessed as needing support with their spiritual needs and staff provided this by accompanying them to their place of worship.

The home had a new training programme in place to ensure staff had the skills and knowledge they needed to provide effective care. Most staff had completed all their essential training courses and those that hadn't were booked to attend forthcoming courses.

We met with the external trainer, based at a local college, who was providing training and support to staff at the home on the day of our inspection. They were delivering a range of accredited and nationally recognised induction and ongoing training courses to the staff team including the Care Certificate, NVQs (National Vocational Qualifications), and Dementia Care Level 2.

The external trainer told us the staff were enthusiastic about their training. They said, "I go to homes all over the UK but the staff here are outstanding. They really want to learn and improve their practice." They also told us, "The staff learn, they put what they're learnt into practice, and they share their learning with the rest of the staff team." A nurse said they had provided training to care workers on tissue viability. These were examples of staff sharing their skills and knowledge to help ensure people needs were met.

People were supported to eat and drink enough and maintain a balanced diet. We saw lunch being served in each of the home's two dining rooms. Staff knew people's preferences. We heard them make comments such as '[Person] always likes chicken' and '[Person] doesn't like mashed potato'.
People were also encouraged to make choices on the day as to what they wanted. For example, staff brought round two different puddings so people could see them before they decided. This was a positive non-verbal cue to help people understand the choices available to them.

Some people needed one-to-one assistance with their meals. We saw a staff member sit with a person and describe their meal to them. They checked the person was happy with the temperature of the food and whether they liked what they were being given. They gently stroked the person's hand to keep their attention and encouraged them to eat, giving them plenty of time to finish each mouthful. This was an example of staff supporting a person with their nutrition in a kind and effective manner.

The cook knew people's likes, dislikes and nutritional requirements. Information about these was kept in the kitchen for reference. People's care records showed that those at risk with of poor nutrition and hydration were referred to dieticians and/or the SALT (speech and language therapy) team for advice and support. Where necessary staff monitored people's dietary intake and weighed them regularly. This had had positive results, for example, one person, admitted with a low BMI (body mass index) and at risk because of

this, had gained weight and improved their heath since being at the home.

The food was well-presented, nutritious and varied. People's cultural needs were considered when meals were planned. Russian and Polish food was on offer alongside English food. The cook told us that one person particularly liked pierogi (filled dumplings of Central European origin) and goulash so these were cooked for them.

Staff had not had specific training in choking prevention. The acting manager said this was covered in the home's general first aid course, but said they would like staff to have specific training in this area and was considering the possibility of providing this.

People had access to healthcare professionals when they needed them. Records showed staff worked closely with a range of external healthcare professionals, including community nurses, dieticians, opticians, dentists, and chiropodists, to ensure people's medical needs were met. A GP from a local practice provided a clinic at the home once a week which was open to anyone who needed an appointment. People had care plans in place for their medical needs which staff followed, taking advice from healthcare professionals where necessary. The staff we spoke with understood people's medical needs and how they were to be met.

One person's medical records needed improvement. The person had a wound that nursing staff at the home were treating. The wound had been photographed but the pictures were poor quality and it was difficult to identity the site of the wound. In addition, the photographs were not dated and the wound hadn't been formally measured. The wound assessment chart did have a measurement recorded, but there was no evidence to show the method by which this had been obtained. The wound assessment chart also indicated that the wound was fully healed on the 10 July 2018 but the person's care plan had not been updated to reflect this.

These issues were raised with the acting manager who said they would ensure this was brought to the attention of staff.

Improvements were needed to the adaptation, design and decoration of the premises to ensure people's individual needs were met, particularly the needs of people living with dementia.

At the time of our inspection there was no directional signage to promote independent orientation and movement around the home. The provider said this had been removed due to redecoration taking place. There was no personalised information, for example, memory boxes or personalised decoration or signage, to support people to identify their own bedrooms. There was a lack of alternative low stimulus areas for people who were agitated by the noise made by other people and there were periods were the noise levels in tone of the lounges were having a negative impact on some people causing them to shout out.

NICE guidance states that providers and managers should ensure environments are enabling and aid orientation. Attention should be paid to lighting, colour schemes, floor coverings, signage, and access to safe external environments.

It is recommended that the provider carried out a review the environment at the home and makes improvements as necessary to ensure it is suitable for the needs of the people living there.

One popular aspect of the environment was the abundance of flowers in the garden and courtyard areas which people and relatives commented positively on. This made a bright and attractive area where people could sit either under cover or outside and enjoy the appearance and scent of the flowers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most staff had been trained in the MCA and DoLS. One staff member, who was relatively new at the home, had not yet been trained yet but was booked to attend this training. Care plans advised staff on how best to seek people's consent. During our inspection visit we saw that staff always asked for people's permission before they assisted them. This meant that staff were working within the principles of the MCA and seeking people's consent to care and in line with legislation and guidance. Some people had restrictions on their liberty authorised by the local DoLS team and their care plans included instructions to staff on how to support them in line with their DoLS authorisations.

Good

Is the service caring?

Our findings

People told us they liked living at the home and said the staff treated them with kindness and respect. One person said the staff were nice and they could choose where how they spent their time. Another person said they got on well with the staff. We saw that relationships between people and staff were good and staff interacted with people at every opportunity.

A relative told us, "The staff are very kind and caring." They said the staff knew their family member's individual preferences, for example in choosing their clothes, and respected their privacy and dignity. Another relative said staff had encouraged their family member to sing a favourite song and listening to this had brought back happy memories for them.

The home had a happy and relaxed atmosphere. There was a range of communal areas and people chose where they sat. Some people preferred to be in the lounges where organised activities took place whereas others spent their time in quieter parts of the home like the conservatory. Staff continually checked on people's well-being and ensured their needs were met.

Some people needed reassurance due to feeling distressed at times. We saw staff providing this. For example, one person became distressed and demonstrated this vocally. Staff distracted them, supported them to feel calmer, and assisted them with the activity they were taking part in. They also talked to the person about one of their possessions that they were particularly attached to. The person appeared to enjoy this conversation. This interaction had a positive effect on the person and improved their well-being.

Staff supported people to express their views and be actively involved in making decisions about their care. Records showed that people, and their relatives where appropriate, were involved when care plans were written and agreed.

Two people told us they preferred different arrangements at mealtimes by taking their meals to a different part of the home. Staff facilitated this by covering their food and enabling them to take it out of the dining room themselves, or taking it to them. Another person had their lunch a bit later than everyone else because they liked the dining area to be quiet. Staff supported them to do this and they told us they enjoyed their meal. These were example of the home having flexible routines to meet people's needs.

Staff respected people's privacy and dignity and promoted their independence. They were discreet when people needed assistance. They knocked on bedroom doors and identified themselves before entering. They continually checked on people's well-being asking them question such as 'Can I help you with that?' and 'Are you comfortable?'. When a GP arrived to see a person, staff ensure they could see the person in their room where it was private.

The visiting external trainer told us that through their contact with the staff team they had noted that the staff understood the importance of confidentiality and data protection, and knew how to challenge stereotypes and provide a personalised service. This was observed during our inspection.

Requires Improvement

Is the service responsive?

Our findings

Since our last inspection care plans had been made more personalised. Those we saw included details about people's preferences and cultural needs, for example how they like to dress, the food they liked, and how they would like staff to assist them with their personal care and chosen routines. This meant staff had the information they needed to support people in a way that was responsive to their needs.

Supplementary files for charts and personal care were completed by care staff. These were kept either in the people's bedrooms or in the area that the person was spending their day. We looked at the charts for repositioning and found these were completed as per the instructions in the care plans which showed that care had been provided as planned.

The care staff and nurse we spoke with were knowledgeable about people's needs and explained how they provided them with personalised and responsive care. For example, the nurse told us, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right." Records showed that staff were responsive to fluctuations in the physical and mental well-being of people and acted to address these.

We looked at how the provider complied with the Accessible Information Standard. This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People's records included information on their communication needs and an assessment of whether they had any needs relating to living with a disability. Some people did not have English as a first language and liked to speak in their native language where possible. Some of the staff were multilingual and able to converse with people in the language of their choice. We observed staff communicating with people in this way and saw that people enjoyed the interaction with staff who shared a language with them.

The home's activity coordinator, who the provider employed for two hours a week, was running a music session during our inspection. This was hugely successful with people enjoying the music and the physical activity that went with it. The activities coordinator played popular songs, sang, and encouraged people to sing along and use a shaker to join in. The session was not only musical but included physical activity as well.

Fifteen people joined in with this activity and clearly enjoyed it. Two of the people were receiving one-to-one care from staff joined in. People were smiling and singing, tapping their feet, and using their shakers. A relative told us their family member, who was unable to vocalise, suddenly burst into song during the session and they found this moving as they could remember the person singing the same song when they were at home.

Some people said they would like more activities at the home and the opportunity to get out into the wider community. They said that care workers did do some activities with them but this had to fit around their

care work. We advised the acting manager of people's views on this and they said they would review the activities programme.

People told us that if they had any concerns or complaints they would tell staff. One person told us, "I'm happy with his care here and my [relative] is too. If I wasn't I would tell them. We haven't needed to complain."

We asked to see the home's record of complaints but were told that no formal complaints had been received. We discussed the benefits of recording informal complaints and their resolution as this is a way of demonstrating that people are listened and responded to if they raise issues. The acting manager said they would consider keeping such a record.

The provider's complaints procedure needed amending to make it clear that it is the local authority, not CQC, who is responsible for investigating complaints. The acting manager said this issue would be addressed.

We sampled people's records to see how people were supported at the end of their lives to have a comfortable, dignified, and pain-free death. We found some good practice. One person had an advance plan for their end of life care which both they, their GP, and their family members had been consulted on. This meant the person would be able to receive the type of care they wanted at the end of their life.

Another person's end of life plan was contradictory. There was a notice at the front of their records stating, '[Person] is for resuscitation'. In contrast, their care plan stated they had a DNAR (do not attempt resuscitation) in place which had been discussed and agreed with their family member. We brought this to the attention of the acting manager who said the care plan belonged to another person with a similar name. The error was immediately rectified. However, this care plan had been in the person's notes since April 2018 and the discrepancy had not been picked up in subsequent monthly reviews. This could have led to the wrong action being taken if a medical emergency occurred.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the provider had failed to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. We issued a warning notice which the provider said they would comply with by 6 April 2018.

At this inspection we found that although there were improvements in some areas the provider was still not compliant with this regulation and had not the met all the conditions of the warning notice.

Although some audits had been put in place these were not always effective and there was no comprehensive audit or other monitoring system in place to ensure quality performance, risks and regulatory requirements were understood and managed.

There was a continued breach of Regulation 12. Although we found some improvements under 'Safe' the provider was still not compliant in this area.

Medicines audits had been carried out but had failed to identify the issues we found at this inspection. They included medicines stored at incorrect temperatures, missing and incorrect PRN protocols, gaps in medicines recordings, a lack of pain assessment tools, and incomplete information about the use of covert medicines. The acting manager said they had not yet carried out the medicines audit for July 2018 but they had purchased some fans to reduce temperatures in storage areas although only one of these was in use.

Staff recruitment files had not been audited and did not always include all the documentation required to evidence that the staff employed were suitable to work in a caring environment.

Incidents reports had been completed but did not always show what action staff were taking to reduce or prevent the risk of incidents such as falls reoccurring. The acting manager had begun a falls audit in February 2018 and while this sometimes showed what had been done for an individual following a fall, for example lowering their bed and providing a crash mat. There was no overview of falls at the home and general factors such as staffing levels were not taken into account. In addition, no evidence that trends had been identified such as the time of day or night, and places where falls occurred.

The provider had not identified that improvements were needed to the adaptation, design and decoration of the premises to ensure people's individual needs were met including the needs of people living with dementia. National guidance on this had not been followed.

At our last inspection the provider's complaints procedure implied that CQC would investigate complaints. CQC do not have the legal power to investigate or respond to specific complaints about care providers. At the time the registered manager said this procedure would be amended. This had not been done and the complaints procedure still did not make it clear that it is the local authority, not CQC, who is responsible for investigating complaints. The acting manager said this issue would be addressed.

One person had a care plan stating they had a DNAR (do not attempt resuscitation) in place. However, this contradicted information at the front of their files stating, '[Person] is for resuscitation'. Despite the care plan having been reviewed monthly since April 2018 this anomaly had not been identified.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

The acting manager told us they were working with one of the directors to develop a comprehensive quality assurance system for the home that would cover all areas and be used to identify any shortfalls with a view to addressing them promptly. They also said this would be part of the home's improvement plan that was also being developed at the time of our inspection.

At the time of our inspection the acting manager was sharing management responsibilities for the home with the registered manager. They told us they were in the process of submitting an application to CQC to be the home's next registered manager.

People and relatives told us they were satisfied with the service provided at the home. One person said, "The staff are good, the place is clean, and the manager is good." A relative told us, "I'd definitely recommend this home, it's secure, clean, it's everything we would want for [family member]. There's a good balance between [staff] being friendly and welcoming but also being professional with clients. It's homely – I like the flowers, they care about details like this."

Since our last inspection the provider had carried out a survey of people's and relatives' views. Nine people competed surveys in July 2018. The results showed most of the respondents felt safe and well-cared for, enjoyed the food, and said they were treated with dignity and respect. People had made suggestions for improvements to the home including 'more television choices', 'more colouring' and 'more people to look after me'.

One relative had returned a survey. They said they were happy with the service, the care, and staffing levels. They made suggestions regarding their family members personal care, and about the best day for the home's coffee meetings.

The acting manager said consideration was being given to the suggestions made by people and the relative. The results of the survey had not been shared with people and relatives and the acting manager said they do this.

Since our last inspection the provider had organised monthly coffee mornings for people and relatives. The purpose of these was to bring people together and give them the opportunity to comment on the home. The acting manager said the meetings were not minuted. This meant we could not see how people and relatives had been involved in the meeting and whether any comments or suggestions they had made had been acknowledged and actioned. The acting manager said that in future notes would be taken at the meeting to demonstrate that people and relatives were being listened to, engaged and involved.

The surveys and coffee mornings showed that people were now being consulted about the quality of care at the home and being given the opportunity to make suggestions for improvements.

At the time of our inspection the provider was working with the local authority and the health service to address some of the issues at the home with a view to improving the service.

The provider told us that following our last inspection a number of improvements had been made, or were being made, to the service including: CCTV in public areas; new policy documentation; a new laundry; a new nurse call system; and the redecoration and refurbishment of areas of the premises. The provider said this work was being carried out to improve the comfort, security and care of the people living at the home.