Superior Care Homes Ltd

The Laurels Residential Home

Inspection report

The Laurels, Bull Lane
South Kirkby
Pontefract
West Yorkshire
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Tel: 01977640721

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16 September 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of The Laurels Residential Home took place on 12 and 16 September 2016 and was unannounced on both days. People and staff living and working at the home refer to it as 'The Laurels.' At the previous inspection the home was found to be in breach of multiple regulations, rated inadequate in every domain and placed in special measures. On the day we inspected there were 22 people living in the home. During this inspection we wanted to see if improvements had been made.

The Laurels provides accommodation and personal care for up to 28 people. Respite care is also provided. The home has two floors, with bedrooms on each floor. There is a secure garden easily accessible via the conservatory with a portable ramp to assist people using wheelchairs.

There was no registered manager in post on the day we inspected, however there was an interim manager who had previously been the deputy 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.

At the previous inspection we had concerns with safeguarding, the premises, staff training and supervision, the implementation of the Mental Capacity Act and care records. At this inspection we found improvements in all of these areas.

People said they felt safe and staff were able to explain the signs of possible abuse, and how they would report this. This was evidenced in safeguarding records.

We found that although there had been significant progress in the development of person-centred care plans this was not always reflected in the risk assessments. We found some information was lacking and in parts contradictory. Staff did not always follow safe moving and handling procedures on the first day we inspected, but after receiving extra training by the second day we observed some improvement. The interim manager had plans in place to regularly review staff competence in this area.

We found staff responded as fast as practicable to call bells and were responsive, but there were times when staff were very busy. This was because most people in the home had high dependency needs.

We observed some issues with medicine administration. Most staff adhered to all expected guidelines but one staff member was seen to administer medication without first checking records or the pot into which they put people's tablets. This lack of scrutiny meant people were placed at risk of receiving the wrong medication.

Staff had access to necessary personal protective equipment. We found there had been extensive improvements made to the property although there was still work to be completed.

People were supported throughout both days with regular food and drinks. However, mealtimes were not well organised as some people had to wait for food for long periods. We saw evidence of timely and appropriate referrals to health and social care professionals.

The service was acting in line with all requirements of the Mental Capacity Act 2005 and in close communication with the supervisory body for Deprivation of Liberty Safeguards applications which had yet to be authorised.

Staff had access to a supervision and training programme. This area was under constant review, with training arranged as needed. We observed all staff had positive interactions with people but sometimes they spoke about people, rather than to them. This showed a lack of respect towards them. On the second day of this inspection we saw several fizzy drinks bottles and half empty coffee mugs on the dado rail which did not aid the feeling this was people's home.

Activities were limited as care staff did not have the time to arrange any and the activities co-ordinator was on annual leave during the week of inspection. We did see some evidence that events had taken place. The home had not received any complaints since the last inspection.

Care records had become more person-centred with individual needs and plans in place for the support people needed. Their evaluations showed changes were made as required but this did not always link across to people's risk assessments.

The interim manager had promoted an 'open door' policy for people, relatives and staff alike so any issues could be raised. It was evident staff felt supported and valued. The registered provider had resourced improvements to the building and had visited regularly to obtain people's views.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe

People told us they felt safe and staff knew how to identify and report any concerns.

Risk assessments and moving and handling practice did not always reflect people's needs.

Staff responded promptly to call bells wherever possible but we saw there were very busy times during the day.

Medicines were administered safely by most staff but not by all.

We found evidence of improvements made to the premises but further work was required.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to plenty of food and drinks during the day but the quality of the dining experience for people was still poor. Food storage and planning had improved significantly since the last inspection.

We found people had access to timely health and social care interventions when it was needed.

The interim manager had a sound understanding of the requirements of the Mental Capacity Act 2005 and had made all the necessary Deprivation of Liberty Safeguards applications.

Staff had received supervision and training. We saw there was an ongoing programme ensuring staff knowledge and experience was up to date.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were patient and kind with people and allowed them to take their time. However, not all staff were respectful towards people as they sometimes spoke over their heads or were seen to ignore them on occasion.

People's consent was obtained before any care intervention and dignity was respected by ensuring people were appropriately dressed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There had been a significant improvement in the quality of care records. We saw they reflected the person's needs and were evaluated regularly.

Structured activities were poor at the time of inspection as staff were busy providing supporting people with their personal care. However, we did see evidence activities had taken place on a daily basis.
The complaints folder was empty as the interim manager told us no complaints had been made.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post at the home. The interim manager had responded positively to issues raised at the last inspection and was transparent about the changes that had taken place. However, there were still breaches in regulations which had not been identified. Where further work was needed we saw action plans were in place.

Staff morale had improved since the last inspection as they felt supported. Ongoing improvements to the premises reinforced this progress.

The Laurels Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 16 September 2016 and was unannounced on both days. This meant the home did not know we were coming. The inspection team consisted of two adult social care inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with seven people using the service and three of their relatives. In addition we spoke with seven staff including one care worker, three senior care workers, the cook, a member of the domestic team and the interim manager.

We looked at eight care records including risk assessments, three staff records including all training records, minutes of meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

We asked people how they felt living in The Laurels. One person said, "It's alright love. I wouldn't be here if it wasn't. I'd tell them straight. They look after us OK." Another person told us "I've not felt scared up to now so it must be OK." A relative we spoke with said, "I feel my relative is safe. There are usually enough staff but they can get busy at times." One staff member we spoke with told us they would report any concerns such as a change in a person's behaviour whether a physical or emotional reaction, and was aware of the safeguarding procedure. Safeguarding records we saw were accurate and reporting was appropriate, with actions taken to limit the likelihood of further harm where necessary. The interim manager explained a protection plan was in place for one person in the home and we saw this was followed by staff.

We observed staff performing a number of moving and handling procedures on the first day of our inspection and had concerns that brakes were not applied on any of the wheelchairs before manoeuvres were attempted. This posed a significant risk as staff supported both the person and the chair during the transfer, which is not safe practice. On one occasion one person could not fully weight bear and fell back into their chair on two occasions before staff took their weight and transferred the person into their wheelchair. This posed a serious risk of injury to both staff and the person transferring.

Staff members did not always give clear instructions to people they were assisting. We heard them say to one person, "Move your frame a bit to face the wall, left, I think, move your feet forward, no this way, no", and then pointed showing the direction. The person looked very confused.

Issues with moving and handling were a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not assisted to transfer safely and the methods used placed them and staff at risk of harm.

We discussed our concerns with the interim manager on the first day of the inspection and they arranged further training for staff following day. On the second day of inspection we saw some improvement in practice and the interim manager planned regular competency checks for staff. In addition, the interim manager planned an urgent revision of people's moving and handling assessments to ensure the correct equipment and method was in place. We saw safe moving and handling practice when equipment was used such as the hoist.

At the previous inspection we had concerns around risk assessments. On this inspection we found risk assessments were in people's care records but the detail did not always correspond with other elements of their care files. We found moving and handling checklists for people which outlined equipment and the number of staff needed for specific tasks. However, there was no methodology recorded if a person needed the use of a hoist. In one record we read the person had low dependency needs and they were 'normal weight bearing'. It also said they were stable but their falls assessment contradicted this as it said they were unsteady. Our observations of this person would indicate they were not able to effectively weight bear and so the records did not accurately reflect the person's abilities. This meant that staff did not have correct guidelines to follow.

In another person's moving and handling checklist it stated they needed two staff and used the shower chair, but in the care plan for personal care it said they needed only one member of staff. We could not find any evidence of a risk assessment for use of the bath lift. This was mirrored in the falls risk assessment which stated the person was at high risk of falls and included a referral to the falls team to see if any measures could be taken to reduce the person's risk and yet the 'tendency to fall' was marked as 'no'.

We checked the nutrition information given to the care staff by the kitchen staff. It was recorded that one person was on a pureed diet and four others were on a soft diet. We asked a staff member what this meant and were told, "Well [name] just doesn't have meats and things." We observed this person being given bacon, sausage and large pieces of vegetables. This posed a significant choking risk to them. We asked the staff member how this person would manage the bacon and sausage and they replied, "Oh well, they can't I suppose, can they?" The staff member then proceeded to ask a further member of staff to put the food in the blender. This second member of staff looked surprised and took the plate away. The person was given a plate of mash and mince 20 minutes later and had to be supported by a staff member as they had fallen asleep. This showed the service had not considered all the risks for that person or followed their nutritional plan. However, on the second day of the inspection we noted this person had food in an appropriate consistency. We spoke with the interim manager about our concerns and they were upset this had happened which they felt had been because staff felt under pressure due to the inspection. They agreed to review the nutritional information and discuss the importance of correct food consistency with all staff as soon as possible.

Issues with risk assessments constituted a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risk assessments and control measures did not reasonably mitigate the likelihood of harm to people.

Accidents were recorded in detail including action taken in each case. Copies were kept in people's individual files. Information included the date and time of the incident, body maps and any equipment involved. All accidents were followed up with at least 24 hour observations of the person to ensure there were no lasting effects. Risk reduction actions were also recorded for each person such as staff ensuring the person had, 'gained their balance before mobilising' and 'to check at hourly intervals'. Incidents were logged in detail reflecting what had happened and how staff had responded, including whether any further external input was needed to support people safely. We saw evidence that any recommendations were included in people's care records. There were a number of accidents where it had been recorded people had 'slipped out' of their chair or bed. The interim manager agreed this needed further analysis, including whether the poor moving and handling practice we had observed on occasion was contributing to this.

We asked people if they felt their needs were responded to promptly. One person told us, "No, there's never enough staff". One relative told us "Sometimes there's not enough staff." One staff member told us, "We could do with some more staff at times." A high proportion of people in the home required two staff to support when transferring. We spoke with the interim manager who advised us they only had one vacancy for bank staff.

The interim manager told us that there were usually seven care staff each day but numbers were less on both days of the inspection due to annual leave. There were five care staff on duty each day including the interim manager. The same ratios applied for weekends and the home no longer used any agency staff but relied on their own bank staff when staff rang in sick. The interim manager said staff were more than happy to cover if needed and had confidence in the staff team to do this.

We observed busy times for staff at different times of the day. At 9.50am one person was assisted to the toilet

and left unattended by the member of staff. At 10am the call bell rang to alert staff a person needed support, but we saw staff responded to another person first. Then another staff member went to assist a person upstairs who had buzzed. This meant a further three minutes elapsed before staff returned to the person in the toilet and the interim manager had to intervene as the buzzer had become an emergency alarm. Later on in the morning staff response times to buzzer calls improved as most people were in the communal lounges.

During the early afternoon staff became busy again as the doorbell rang on a few occasions in addition to people's call bells. At 2.30pm a call bell rang for nine minutes at and then another for a further three minutes a little while later. Staff were busy attending to people and appeared rushed for around 30 minutes. This seemed to coincide with the handover time when staff coming on duty were updated by the senior member of care staff on in the morning. One person spilt tea on themselves and rolled up their trouser leg. No staff were in the lounge at the time so we had to alert the interim manager who came and mopped up the spillage and checked the person had not been harmed. On the second day we saw staff responded promptly with a person who had vomited in the corridor. The person was supported to the bathroom and, once they were more settled, encouraged to return to their room to freshen up. This meant that there was variation in how staff were able to respond to people's needs depending on times of the day when demands on staff time were greater. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were not always enough staff to meet people's needs promptly.

Staff were only employed after an interview, and after two references had been obtained and a Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people working with vulnerable groups. One staff member we spoke with confirmed they had not been able to start employment until their DBS check had come through. All new staff had an induction and spent time shadowing more experienced colleagues. New staff were also signed up for the Care Certificate which is a set of agreed minimum standards for all new care workers to meet. The interim manager allowed staff up to six weeks to complete the workbooks and they were verified by senior staff. This meant that staff's competencies were being assessed in a timely manner.

We observed four different medication rounds. During the first one we watched the staff member administer medication to people in their rooms. On each occasion the staff member took out a pre-filled pot of tablets from the medicine trolley and gave them to the person. We asked the staff member how they knew which pre-filled pot of medicines to give from the trolley. They told us each person had their own drawer in the medicines trolley and they had retrieved the pre-filled pots from each person's drawer. They told us they had prepared them in advance as they knew who was to receive medicines and it was quicker. We noted the trolley was moved around the home, including down a large slope which meant there was a risk tablet pots could fall over. In addition, without the checks at the point of administration there was no guarantee all medicines had been given in full or to the right person. When we asked the staff member how they knew who had received what, they said, "I just do." We spoke with the interim manager about this and they agreed to remove the staff member pending further training and competency checks.

After one person was given their pre-filled pot of medicines we saw they were offered a drink. We did not see the staff member either check the medication pot or the medication administration record (MAR) to ensure the correct medication was given. This posed a serious risk to people of receiving the incorrect medication.

Another person was lying almost completely flat in their bed and the staff member tipped the person's tablets into their mouth while holding their head up slightly. This put the person at significant risk of choking. We noted the staff member remained in the room to ensure the person had taken their tablets but did not sign the person's medicines administration record. A further person also in bed was left with a large

tablet in their mouth. The staff member told us, "They like chewing it." We saw this tablet was then recorded in the person's MAR as taken, although the person was left with the tablet in their mouth as we left the room with the member of staff.

We saw MARs had been completed in advance of people receiving their medicines during the morning medicines round. This was a falsification and might not be a true reflection of what a person had actually taken. This was also observed during the lunchtime medication round where MARs were signed prior to the person actually receiving their medication.

Issues with medicines administration constituted a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not administered safely, people were placed at risk of choking, medicine was administered without checking MARs and records were completed in advance of medication being given. We informed the interim manager; they agreed to remove the staff member from medicine administration until they had completed further training.

We observed a further medication round completed later the same day by a different staff member. They demonstrated good practice by having all equipment ready on the medicine trolley, MARs open and not signed until after the person had taken their medication and stock checks taken during each person's administration. The interim manager was also able to explain the procedure for safe medicine handling.

People were asked if they were in pain and we saw appropriate medication were given for this. Staff were given clear guidelines in the PRN (as required medication) protocol. They clearly stated when to administer such medication and the person's ability to communicate their needs for such medicine was also noted. This was person-centred as it included specific phrases people might use if they were in pain or discomfort. Staff knew to call the GP for a medication review if a person needed PRN medicines regularly or if they displayed side effects. Records were completed when PRN medicines were administered to explain why it had been necessary to give the medication.

Medicines were stored in a different room to our previous inspection. We saw it was very tidy and well organised. Fridge temperatures were recorded twice daily and were at appropriate levels; however the room temperature monitoring revealed significant concerns as on only one occasion in the past three months had the temperature fallen below 28°C. Most medicines need to be stored below 25°C to retain their effectiveness. We asked the interim manager what they were doing about this and they explained that they had bought a fan, which was in use, and plans were underway to put in an extraction system. However, there was no date for this as they awaiting contractor availability.

MARs contained staff signatures which were dated to evidence who was authorised to administer medicines. Each person had a medication profile which included their name and preferred name, date of birth, GP and pharmacist details. They also specified any allergies. MARs contained stock levels as medication was boxed rather than in blister packs. Most boxed stock levels matched that recorded on the MAR. We found one incidence of a missing tablet which the interim manager immediately took action about by logging it and contacting the staff member who had administered it to start an investigation. Dates of opening were recorded on liquid medication and where community nurses had been supporting people their instructions were followed. We checked the Controlled Drugs and found these to be recorded and stored correctly with matching stock levels. The issues from the previous inspection around storage, PRN protocols and controlled drugs records had all been resolved.

There had been an improvement to the premises since the previous inspection. Personal protective equipment was available in all communal areas including bathrooms. Thermometers were available for

staff to use in the bathrooms to check water temperatures were with guidelines on acceptable levels. However, there were still areas that needed further work. We noted the bathroom in zone six had no hot water tap handle on the washbasin. A new shower had been installed but the broken shower fitting had been left on the wall and it was very sharp. One person's bedroom had a strong odour which the interim manager was aware of and agreed to see how this could be rectified. The blue lounge patio door was cracked (although it posed no immediate risk to people in the home) and the dining room patio door could not be opened as the hinges were broken. Both of these issues had been reported and were awaiting contractors to complete the work.

We saw the home had detailed personal emergency evacuation plans in place for all people in their files and in a 'grab' bag for use in an emergency. This included all relevant information for people and staff in the home along with the medication people required. We also saw evidence of regular fire safety checks both in terms of evacuation procedures and equipment checks. All staff had received the necessary training. This meant the interim manager had ensured that people were kept safe and the home had a robust evacuation plan in place.

Requires Improvement

Is the service effective?

Our findings

One person said, "The food is nice, that's one thing." Another person told us, "I love jam sandwiches", and we saw them eating these at lunchtime. One relative commented, "The food is first class, there's always something to eat and drink, and it's usually what my relative likes."

We had concerns from the previous inspection about whether people we supported with nutrition and hydration. On this inspection we saw people being encouraged to have regular fluids during the day. One person was walking around and a staff member guided them into the lounge for 'a cup of tea'. Another person asked for a drink and we saw they were offered a choice of tea, coffee or juice. During lunchtime people were spoken with by staff and we heard one member of staff say to a person, "Did you enjoy your lunch? It's warm today."

People were encouraged to move into the dining room from 12 noon but no food was available until 12.30pm. One member of staff took the lead for serving the food from the trolley, using a pre-completed list indicating people's choice and this was double-checked with the person in advance of them receiving their meal. People were offered a choice of apron to protect their clothing, some were fabric and some disposable. However, we noted there were no condiments or cutlery on the tables. The cutlery was given to people out of the dishwasher cutlery tray as their meals arrived. This meant that there had been little preparation in advance of lunch time and people's lunchtime experience was poor.

The staff member serving up the meals directed other staff members to take specific dinners to people, mostly for people choosing to remain in their rooms. It was evident they were following the list in order of entry rather than observing people around them. One person looked bemused at not having any dinner when everyone around them was eating. This person was not assisted to eat until 1.05pm, some 30 minutes after other people had received their meals, although when they were, it was a positive and personal interaction.

Some people were still waiting for their food in the lounge at 1.10pm and one person did not get a drink until 1.15pm after they had eaten their meal. Two people in one lounge had fallen asleep and a staff member said, "They're out of it. We'll give them a late lunch when they wake up." We did observe this happened at 2.30pm which meant that staff were ensuring people had access to food and drink when people needed it.

People were not always offered full choices at mealtimes. We saw one member of staff offer a person angel delight or yoghurt, and yet there was fresh fruit and rhubarb crumble and custard also available. Another person was given some angel delight and asked if they had had enough. However, as they did not reply the dessert was just taken away. One person had left most of their meat pie on the first day and was asked by the staff member if they had enjoyed their lunch; the amount of food left did not appear to register with them. On the second day this had improved and we observed staff engaging with people about their choices and encouraging people to eat more where they wished to.

We spoke with the kitchen staff who showed us the fortified food and fluid list to ensure that people at risk of weight loss were receiving adequate levels of nutrition. We found that the pantry and freezer was well stocked with food in the appropriate storage area. The cook explained they had the control over ordering of the food and managed the stock levels themselves. Dates of opening were recorded on packets to ensure they were not used beyond their expiry date.

Records were kept of each person's dietary needs which were updated regularly by care staff. The cook had access to people's choices and food was prepared in line with these individual preferences. Fresh fruit and vegetables were a regular feature on the menus. Staff were able to access the kitchen out of hours to provide food for people, such as sandwiches or toast, if they were hungry. We saw evidence of new kitchen equipment in place. This showed the home had responded well to the previous inspection feedback to address concerns around food storage and preparation.

We observed one person had dry skin on their legs and a staff member told us, "[Name] fell out of bed which is why they have a dressing. There's something wrong with their skin but the district nurses come in to change the dressing." We saw in this person's care record that the community nurse was providing nursing care as the staff member had indicated.

Another person told us they had been very unwell and their illness had only been identified by the interim manager who had sought medical attention promptly and fought for the right treatment for them. The interim manager told us they had suspected an infection and sent samples to the GP for testing. This had resulted in a hospital admission for the person and the interim manager had advised the hospital the person could not be discharged until they were well again. This showed the interim manager had a good understanding of infection prevention and control, and was also able to advocate on behalf of people in the home effectively.

We found comprehensive records of visits by GPs and community nurses as well as other healthcare professionals, such as occupational therapists and social workers. There was also a list of forthcoming appointments for people at hospital, opticians, the chiropodist and the dietician which demonstrated the home was up to date with people's needs and requirements. It was clear from care records that advice and treatment was followed up for people and one relative told us this had got significantly better over the past few months as previously they had had to remind staff to apply creams and other topical medication.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One staff member told us, "If a person had a DoLS in place I would not let them leave the home unaccompanied, would stop them leaving and tell the senior. If they had no DoLS they would be free to leave but would try and persuade otherwise if I was concerned about them." We saw the interim manager had appropriately applied for DoLS for 14 people although none had been authorised by the supervisory body, despite applications having been made in March 2016. This meant the home had made improvements in this area since the previous inspection.

We asked one staff member about their understanding of mental capacity. When asked how they assessed

people, they replied, "You must consider everyone has capacity to make their own decisions, even if they are not wise decisions." We saw mental capacity assessments for specific decisions such as a person's ability to take medication and their living arrangements, and four people had them in place in relation to the provision of bed rails which had been discussed in conjunction with the community nursing service and were reviewed at regular intervals.

In people's care records we found copies of Lasting Power of Attorney (LPA) records although not all were registered and no one had LPA for health and welfare to enable family members to make decisions on behalf of their relatives. The interim manager had conducted mental capacity assessments indicating where a person lacked capacity and had followed best interest decision making guidelines in regards to key decision making.

The interim manager was aware of the importance of assessing staff competencies on an ongoing basis and had developed an action plan to incorporate this as part of their regular supervision and appraisal process. We saw the supervision schedule which evidenced two-thirds of staff had received supervision in August and September 2016 (up to 12 September 2016), and further sessions were planned. All staff had received a scheduled annual appraisal. One staff member who had started in April 2016 told us they had received two supervisions during this time as well as attending staff meetings and we saw evidence of this.

We checked staff files and saw staff had received training in all key areas such as manual handling, fire safety, medication, first aid, health and safety, nutrition and hydration, infection control, dementia awareness, safeguarding, mental capacity and supporting people with complex behaviour. One staff member was able to describe in detail the concerns around a choking risk and the importance of a pureed or soft diet in such situations. Considerable planning had been completed around staff training needs and we saw evidence where gaps were identified, actions had been put in place to remedy them. The interim manager advertised training widely in the home and stressed to staff the importance of attending.

We saw staff were effective at communicating their whereabouts with each other during the day and also about significant events for people in the home. This was reflected by a relative who said, "Staff tell me more far more than they used to about my relation." They felt this was a great improvement. We also saw written reports of key information from each shift to inform staff taking what had gone on. This included records of visiting health professionals, pressure area care, any behaviour issues, accidents and general observations. People's records had a health and wellbeing daily statement which included food and fluid intake, any pressure area care given and space at the bottom for the member of staff to raise any issues with the person in charge.

Requires Improvement

Is the service caring?

Our findings

One person said, "It's so lovely here, you're so nice." Another person told us, "Staff are really lovely, they know all about me." One relative we spoke with said, "My relation is clean and well fed, and the staff are lovely." Another relative told us, "Staff are very good with people. They show understanding and care. I don't have worries asking anything".

At the previous inspection we found issues with people not being treated with dignity and respect. At this inspection we saw one member of staff asking one person if they were ready to move into the lounge. This was done in a friendly manner. We also overheard a staff member assisting a person in their room who had become agitated and raised their voice. The staff member responded with reassurance and was very patient. Just prior to lunch we observed one member of staff re-arrange a cushion for one person to help make them feel more comfortable and remind another person to drink their tea. People were reminded to use their walking aids to move into the dining room for lunch. One person was asked, "Would you like to come for dinner?" by a smiling and friendly member of staff. They explained to the person what they were doing and why.

During the latter part of the first day we observed staff being attentive to people's needs. They were patient when talking to people, asking if they were alright and if they had any pain or needed anything. One person who had chosen to remain in the conservatory was frequently checked to ensure they were OK. Despite how busy they were we did not see any members of staff rush people when escorting them to the toilet. We heard one staff member say, "Here, hold my hand and I'll show you", when the person required the toilet. Staff continually gave reassurance. When people became more agitated we saw staff intervene and distract them well. One person was seated in a recliner chair and we saw staff fetch a blanket to cover their legs to protect their privacy. Interactions were much more frequent during the afternoon and people responded well.

However, we overheard one member of staff say to another, "I'm just going to make a start with [name]", over the person's head which showed a lack of respect. A moment later the same member of staff said, "Is he walking or what shall we do?" Again, this was in front of the person. We saw the person being supported by two members of staff into the conservatory. Just after this a person living in the home asked if they could go to the toilet. The staff member responded by saying loudly, "You want the toilet. OK then." They did assist the person.

Later on during the morning one member of staff called out, "[Staff Name], can you get me some gloves as [name of person] can't get their teeth back in?" On the second morning we observed two people in one lounge, one of whom was asking for the toilet. This request was acknowledged by a member of staff who told the person they needed to seek another member of staff to provide support. The person became increasingly agitated but the member of staff walked past the room several times and did not offer reassurance. The request was at 9.50am and at 10.10am no one had responded, and the person stopped asking for help.

During this time the call bell was ringing continually, so much so that staff commented on how busy it was.

Two staff were supporting one person in the lounge at this time to move from their wheelchair to an armchair via the hoist, which we saw was done safely. During lunchtime one staff member spoke with another very loudly announcing they were, "Just going to feed [name]." Although it was important for staff to make clear their intention this was not done with any respect towards the person waiting for their meal. On the second day of the inspection we found half-finished bottles of fizzy drinks and mugs of coffee on the picture rail outside of the lounges. This made the home look untidy and not respectful of the fact it was people's home. We spoke with the interim manager about our concerns and they told us staff were scheduled to training around privacy and dignity on 29 September 2016 as they had realised this area needed further development. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's dignity was not always respected and staff did not show appreciation of confidentiality.

We saw the interim manager had developed a list of 'champions'. These are members of staff who take a lead in a particular area and share this knowledge with other staff. However, despite there being a dignity champion in the home we observed staff on a number of occasions, talking about people rather than to them. It was evident that the interim manager had made an effort to address this area of concern from our previous inspection as there was a display on the wall of the ten dignity standards which served to remind staff of the importance of respectful conduct. No one had an advocate although we saw this service advertised throughout the home.

Requires Improvement

Is the service responsive?

Our findings

One relative told us, "My relation gets a choice of when they go to bed. I am able to visit whenever I like. I have no concerns at all." They then said, "The home sometimes has a singer or plays ball games. People join in when they can. They used to have a film night."

On the first day of inspection we found eight people sitting in the dining room at 9.30am but there was nothing on the tables. Music was playing on the CD player. Staff were in the process of moving people from the dining room to one of the lounges. At 11.20am five people were in the blue lounge and the TV was on but no one was watching it. It would not have been possible for all people to have seen the TV from its position in the room. Three people were asleep and the other two were sitting passively. The home had an activities co-ordinator but they were on leave the week we inspected. It fell to staff to do activities in their absence but they struggled due to the amount of support required by people. On the second day we heard people being asked their preference of films to watch with synopses of the films given to aid decision making.

A staff member came into the lounge and chatted with people in a kind and caring manner, asking them if they were OK or needed anything. They also asked which visitors people would be likely to have later in the day, clearly showing their knowledge of people's families.

We saw a display of photographs in the corridor of recent activities such as the summer fair and 100th birthday celebrations for a person in the home. Activities were listed for the first day of our inspection but these were not carried out due to a lack of staff availability. A vocalist and guitar player was scheduled for 23 September 2016. We found in the activities file a record of recent entries when people's social needs had been considered; this included their life history which had been discussed directly with people resulting in a care plan reflecting these experiences.

We found care records had improved since the last inspection. They were all ordered in the same format with key information at the front of each person's file. This included next of kin and GP details. Each file also had life stories for people, although some were more detailed than others. Life histories can help staff to get to know the person and significant people in their lives.

Each care record had an outline of the person's specific needs such as mobility, continence, nutrition, personal hygiene, medication and communication. This helped staff to have a quick overview of a person's main needs. Each person then had a person-centred care plan reflecting their individual needs and how these needs were to be met. They were all dated and cited any associated risks. We saw evidence of monthly evaluations which incorporated significant changes for that person. In one record we saw that a person's declining mobility had been noted and that they now required two staff to support. This person had also been noted as being at risk of weight loss and we saw referrals to the dietician to look at this issue further.

Records included comments such as, "[Name] can independently choose as long as staff offer options. [Name] eats slowly and needs staff to allow plenty of time to finish", and, "Needs time to weigh up options. Can choose own clothing if shown different options." We saw this being actioned on both days for this

person. Care records had been signed by the person when they had the mental capacity to agree to them and we saw where one person liked to have an alcoholic drink before bed, an appropriate risk assessment was in place to manage this and the potential conflict with their medication.

Each person's care record contained a dependency tool which highlighted their abilities in regards to mobility, personal care, communication, nutrition, continence care and social interaction. One person's record indicated they were occasionally 'violent' but on speaking with the interim manager they told us no one had challenging behaviour. No reasons for this behaviour were given although we noted in the care plan the person's mental and physical conditions impacted on them significantly at times. Equally this record stated the person was 'normal weight bearing' whereas we saw they used a wheelchair. The interim manager acknowledged some of the assessments needed closer review.

Mid-morning on the first day of our inspection we heard one person talking to a member of staff. They were quite agitated and complaining that items of their clothing had been going missing. They claimed that another person had been wearing their clothes and they felt this was wrong. We checked later to see if this had been recorded as a complaint but found it had not. On speaking with the interim manager they advised us this was a frequent accusation made by the person. However, without evidence of a possible investigation or record of a conversation this meant the person's concerns had not been acknowledged or followed up.

We saw from the residents' survey that every person in the home knew how to complain. The complaints policy was fully accessible to all in the reception area of the home. There was also a display of thank you cards. One relative we spoke with told us, "I've not had to complain recently." The interim manager said they had not received any complaints since they had started in their role but was aware that previous issues had gone directly to the registered provider to deal with.

Requires Improvement

Is the service well-led?

Our findings

One person said, "I do like it here. The staff are all so nice." Another person told us, "I like it here. It's a nice place." A third person told us, "We're well looked after."

One relative we spoke with felt there had been improvements since the last inspection. They told us, "I felt so guilty when I heard what inspectors had found last time so I always go to the manager if there's anything wrong now. I think they've worked hard…There's been a lot of changes of managers and we are not always told what is going on." Another relative told us, "The manager has changed. I sometimes see the owner but they don't always speak to me." A third relative said, "The interim manager is very approachable and knows what they're doing. I would be confident raising any issues. I was recently asked to complete a survey."

One staff member said, "I think things have improved. Staff morale has." Another staff member said, "I think the interim manager runs the home well. They have an open door policy so I can approach at any time and raise any issues. I feel valued in my role." The interim manager told us "Staff morale is up after a long bout of negativity. There have been lots of changes of managers which has been disruptive. I am currently working a twelve hour day to keep things moving in the right direction. I have put a lot of systems in place but recognise it will take time to embed new ways of working." The interim manager was also supportive of the registered provider who they said visited regularly and completed some of the administration tasks to alleviate the pressure. This was endorsed by staff who said they saw the registered provider often and who spoke with staff and people in the home.

All equipment had been checked and serviced in line with requirements. The registration certificate of the home was on display but the ratings were not. However, the home's latest inspection report was on the front noticeboard and the interim manager agreed to display the ratings immediately. Copies of the previous inspection report had been given to relatives and meetings held to discuss this.

We found the interim manager very open and transparent in relation to their willingness to share information and to show us where improvements still needed to be made. They explained how they had only taken over as interim manager following the departure of the manager at the end of August 2016. However, they had been involved as a deputy manager since the departure of the registered manager in February 2016 and since that time had helped manage all elements of the service. This included the recording of accidents and incidents, monthly audits, revising all care records, developing a new daily health and wellbeing form, ensuring people were weighed according to their care plans, applying for DoLS, and improving the premises and environment. They were mindful that further development needed to occur in regards to quality assurance processes as these had been limited to accidents and incidents, and safeguarding concerns thus far. This was necessary as we found continued breaches of Regulations 10 and 12 as the risks from poor medication administration and moving and handling practice had not been identified prior to the inspection and there was still an issue with people being treated with respect and dignity. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks were not always monitored and mitigated effectively enough.

Following on from a local authority visit three days prior to our inspection the interim manager had generated a comprehensive action plan with specific tasks and dates of completion for areas identified as of concern. Some of these we noted had been actioned immediately which demonstrated they were keen to ensure improvements were timely.
In accordance with the regulations, services are responsible for notifying the Care Quality Commission about certain incidents, accidents or events. The interim manager had sent in appropriate notifications as required since they had taken over, although some were missing from earlier in the year. They sent in a notification regarding the medication error we found on the first day of the inspection by the time we returned on the second day. This showed the interim manager was responding as required under the duty of candour regulations and demonstrated improvement from the previous inspection where no notifications had been made.

Staff had access in the main office to key information such as the protocol for ordering medicines, list of keyworkers and GPs, and more general information around mental capacity and weight management. There was a photograph board of all staff with their name clearly printed and the rota was on a whiteboard outside of the lounge which was updated each day showing which staff were on duty.

We saw copies of quality survey questionnaires from July 2016. One comment said there needed to be more activities and entertainment and another said it would be good if staff had more time to chat but most of the comments were positive by people in the home. In the staff surveys conducted at the same time comments included "excellent quality of training", "things are getting a lot better" and "a more friendly atmosphere." Relatives' surveys included comments such as "very satisfied", "happy with care", "staff excellent, doing a fab job" and "well looked after". Negative comments were focused on missing clothes on occasion and perhaps people needing to be offered showers more often. We spoke with the interim manager to see what analysis or follow had been completed following these and they advised us that although the comments had been discussed, no follow up had yet occurred but we were shown the action plan where it was scheduled.

One relative said, "I have attended resident and relatives' meetings and there is another one soon. Things have improved as much more notice is taken now. My contact details were updated and I'm being kept informed." The minutes evidenced that concerns had been listened to and discussions were open and honest.

The interim manager felt supported by the registered provider who spoke to them almost daily. The provider also visited the home weekly. The interim manager said if a need was identified there were no issues around resources or if equipment needed to be obtained. The estate issues we found at the home were waiting for contractors to give dates and were outside of the scope of the interim manager or registered provider. On the second day of inspection two people were assessed by a visiting occupational therapist who had advised the interim manager they now both needed to be hoisted. The home only had one suitable sling but the interim manager contacted the registered provider for immediate authorisation to order another one as they were aware of the risk of infection and this was duly given. This showed the home was responsive to guidance from other professionals.

We asked the interim manager what he felt the key risks to the home were. They discussed issues raised by a recent external audit (August 2016) which had included further necessary improvements to the premises, updates to staff files and more detailed quality audit processes to be developed. It was evident the interim manager had responded to this positively and created clear action plans with some of the tasks already completed.

We also asked the interim manager what they felt had been achieved and they said staff were much more responsive and willing to learn. They also felt staff knew what was expected of them and would raise any issues. They said they identified good practice through sharing of knowledge, feedback from families about staff conduct which was then shared with staff in staff meetings. All these initiatives had helped raise staff morale and we saw this in minutes of meetings. The interim manager told us they had plans in place to create a compliments wall to reinforce positivity within the home and to promote good practice. This meant the focus was on improved care for all the people in the home and that staff had easily accessible reminders about what this was in practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always promoted and staff did not respect confidentiality.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were issues with medicine administration with one staff member and risk assessments did not always correspond with people's care records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks were not always monitored and mitigated effectively enough.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs promptly.