G Qadir

Springfield Nursing Home

Inspection report

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Tel: 01257470140

Date of inspection visit:
11 May 2016
12 May 2016

Date of publication:
26 July 2016

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

We inspected this service on 11 and 12 May 2016. The home was last inspected in April 2014, when it was compliant with the outcomes inspected. This is the home's first comprehensive inspection under the changed methodology.

The home is a nursing home providing nursing and residential care for up to 40 people. On the two days of the inspection there were 39 people living in the home.

The home is an extended period building over two floors. The home has communal areas on both floors including lounge and dining room provision. The kitchen is located on the ground floor and the laundry is a designated building in the grounds. The gardens are spacious and well maintained. We saw people enjoying the outside space during the inspection. People appeared settled and we saw some preferred to stay in their room and others liked to utilise the communal space.

The home had a registered manager at the time of the inspection who knew the home well. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was in breach of four of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014 including identified issues with staffing, how the home acquired consent specifically within the principles of the Mental Capacity Act 2005, how the building was maintained, the records kept and quality audit.
There were a number of issues with how the home was maintained. This included obstructed fire exits, a lack of available PPE (Personal Protective Equipment), cluttered bathrooms and inappropriate storage of clinical items. The provider was required to take action to improve this.

The home had not fully embedded the principles of the Mental Capacity Act 2005 and more work was required to meet the requirements of the Act and the associated Health and Social Care Act regulation for consent. We found most consent that was acquired was given by family members rather than individuals themselves. When family members have power of attorney this is appropriate. However, we found required best interest decisions and capacity assessments had not been completed in some circumstances where family members did not have power of attorney.

When we looked in people's care files, we found information was difficult to find and care plans and the records for meeting people's needs were not routinely updated to ensure assessments and plans of care reflected the care being delivered. We found the home needed to address how records were kept, collated and used to inform assessments and care plans. We also found the quality audits had not been routinely completed in the last couple of months and this had an impact on the quality of the service provided, as

identified within this report.

The home had a pleasant and calm atmosphere. The staff and people who lived in the home interacted well and people told us there were good relationships between staff and residents. However, we noted people were left in wheelchairs for too long and some for the majority of the day. Staff and people who lived in the home told us there was not enough staff to attend to people's needs as they would like. Dependency assessments had been completed but the scores had not been used to determine if there was enough staff. There were particular issues when staff called in sick at short notice. The provider was required to take action to ensure there was enough staff at all times.

We have made five recommendations within the report. Staff had not received recent safeguarding training we recommended the provider ensures all staff receive up to date safeguarding training to refresh their understanding. The provider used a training matrix to keep track of the delivery of training but this was not up to date. We recommended the staff trainer ensures the training matrix is kept up to date. This would allow them to determine the appropriate and required training to be delivered to ensure mandatory training is completed as it should be. We have recommended the provider takes steps to ensure people are involved with the reviews of their care plans and we have recommended the provider updates their complaints poster to reflect the regulated activities regulations 2014.

Medicines in the home were managed well and records were accurate and up to date. The staff administering medicines had all the information they needed to do so safely. Medicines were stored correctly and the stock was all accounted for and within the use by date.

Staff were recruited to their roles in a fair and transparent way and all the required suitability checks were completed before staff commenced in the role. Staff were well supported to ensure they could complete their role effectively.

The kitchen was managed well and the people in the home enjoyed the food on offer. The chef had liaised with people and their families to gather people's preferences and clinical and care staff shared information with the chef to ensure people's dietary requirements were met.

Visiting professionals were happy with how staff at the home worked with them. We were told by external professionals that their care plans were followed by staff at the home and could see evidence of this in the care files we reviewed.

Staff treated people in the home with dignity and respect at all times. People in the home spoke highly of the staff and how they were treated. We saw people were given choices in their daily routine and laughter was common place. Some people told us they would like to be more formally involved with developing their plans of care and the registered manager assured us this would happen.

We reviewed the available information the home used to ensure people's needs were met. We saw assessments and care plans were in place that followed best practice guidelines including the use of the MUST (Malnutrition Universal Screening Tool) and Waterlow (pressure area) assessments. We saw the home undertook specific monitoring of people's needs including their weight and personal care needs. However, we found information was recorded in a number of different places. We saw information on handover sheets to ensure staff knew the priorities for people each day and saw information in the diary that showed us some aspects of the care plan were being recorded there.

The home had a comprehensive complaints policy which was implemented and followed as and when

required. The home learnt from the issues identified within complaints and took steps to reduce the same issues arising. Information was shared with the staff team to ensure the steps were taken.

A set of quality audits and collection of regular feedback from people who used the service allowed the management team to address concerns as they arose. We saw the home set actions from audits and identified leads for their completion. Actions were reviewed to ensure they had been completed. Not all the audits were up to date.

Staff were happy at the home and they were supported by each other and the management team. A comprehensive set of policies and procedures were in the process of being reviewed and information was being disseminated to the team through team meetings and weekly training sessions.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The home had a recently reviewed contingency plan and the emergency evacuation plans were to be reviewed.

There was not enough staff to meet people's needs in a timely and appropriate manner.

We saw the home assessed the risk to both the environment and the people living in the home.

Medication was managed safely and people had dedicated plans of care for their medications.

Some minor amendments were required to how the building was maintained to ensure it was fit for purpose. This included the accessibility of PPE (Personal Protective Equipment) and ensuring fire exits and doors were always clear.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported with their nutrition and hydration but better records were needed when people needed extra support.

The home had not fully adopted the principles of the Mental Capacity Act 2005. Consents for provision of care had mostly been acquired from family members.

Staff spoke highly of the training they received and we could see staff were well supported with good induction, ongoing team meetings and appraisal.

Is the service caring?

Good

The service was caring.

People had a dedicated key worker and this had led to better

person centred care.

We saw people were treated with dignity and respect and saw good interactions between staff and the people who lived in the home.

We saw people had a choice of what they ate at meal times and people told us they could go to bed and get out of bed when they wanted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw activities taking place at the home and people told us there was generally something to do if they wanted to.

The home worked well with external professional agencies and professionals we spoke with told us the home's staff followed their plans of care.

People were not formally involved with their care planning reviews and six monthly reviews as identified within the consent to care form, were not taking place.

Information about people's care and support needs was kept in different places. The information was not always collated to inform assessment and review in a timely way.

The home had a comprehensive complaints policy and procedure and we saw this was followed.

Is the service well-led?

Requires Improvement

The service was not always well led

We saw a system of quality audit which was monitored and actioned appropriately. The home took regular sense checks on how people perceived the service and we saw this was also actioned as required. However this had not routinely been done of late and this had an impact on quality

The home had a comprehensive set of policies and procedures, which were in the process of being reviewed.

Staff were happy working in the home and there was an ethos of maintaining and developing people's independence.

Springfield Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 May 2016. The first day was unannounced. The inspection team included two adult social care inspectors and a nurse specialist advisor.

Before our inspection, we reviewed the information we held about the home, requested information from the local clinical Commissioning Group (CCG), the local authority contracts team, the local safeguarding team and Healthwatch. We also looked at information about the home held in the public domain.

During the inspection we spoke with 13 staff including the registered manager, nurses and carers. We also spoke with the maintenance person, cooks, domestic and administrative staff.

We spoke with 11 people who lived in the home, four relatives and a visiting professional.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 14 people's care files and looked at supplementary records available for everyone in the home. We observed the staff interactions with people and how people were supported including at meal times and during medicine rounds. We looked at six staff files and took note of the staff training that had been completed.

We looked at all areas of the home, including the kitchen and laundry, all the communal areas which included lounge and dining areas and bathrooms. We looked in people's bedrooms and in the available office space used by staff to keep records and complete their duties.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person told us, "I lived on my own and I feel much safer here." Another told us, "Safe, yes I'm safe, I'm home here and well looked after."

On the day of the inspection the home was clean and tidy. Some areas of the home were tired and we were told of the programme of redecoration currently in place. However many of the skirting boards and handrails were chipped and the wood was exposed.

We noted some areas of the home did not have easy access to PPE (Personal Protective Equipment) and clinical waste. This included many of the bathrooms and toilets. We also saw the lid of one of the clinical waste bins was broken which could pose a risk of cross contamination if staff had to manually close the lid.

The laundry had a good system in place to manage the clothing of the people living in the home including a dirty and clean flow within the room. However the laundry itself required cleaning and there was a large build-up of dust and dirt behind the machines. There was no dedicated risk assessment for the safe management of the laundry and its equipment.

We observed a linen cupboard in one of the home's hallways which held continence pads and slings for use with the hoists. The pads were kept on the floor and the floor was dirty. There was a notice on the door to say the door needed to be kept shut and locked but it was open.

When looking in some people's bedrooms we noted the mattress did not fit securely into the bed frame. We saw in one room, a folded quilt was used to fill the gap. This left a risk of a potential accident if the filler came loose from the gap and the mattress moved within the bed frame.

We noted some of the fire doors were difficult to close and we saw one that was obstructed by a hoover and a draft excluder. Many of the bathrooms had a lot of equipment stored in them and one in particular was a hazard as the floor was so cluttered.

There were some aspects of the premises and the equipment used that were not clean, suitable or properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

Each person living in the home had a dependency assessment calculated from their specific care plans. The plans we reviewed were accurately reflected within the person's dependency assessment. However a tool was not used by the home to convert these scores into the required staffing to ensure people were supported. This left the potential for the home not to have the required number of staff to meet people's needs.

We spoke to the registered manager, staff and people living in the home about the availability of staff. We received mixed responses but all told us there were issues when staff called in sick at short notice. There

were also vacancies at the home, which the registered manager was currently recruiting to.

We observed people sat in wheelchairs for too long. Many people living in the home required the support of two staff for transfers from wheelchairs to seats and back again. All too often we saw people were left in their wheelchairs and some for the duration of the day. We spoke with the registered manager about this, who acknowledged this was a problem. Staff also told us sometimes people had to wait to receive support and that they did not have the time to talk to people. People living in the home echoed this.

We anticipated that the dependency assessments would support the requirement for more staff and urged the registered manager to complete this exercise. We also discussed the use of agency staff and acknowledged that this may be required until the current vacancies were filled.

At the time of the inspection there were not enough staff available to meet the needs of people in a timely way which is a breach of regulation 18 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

Staff interactions we saw were considered and staff took their time. We saw staff supporting people explaining what they were doing, as they were doing it.

Available records showed some staff had not completed training in safeguarding for four years or more. Staff we spoke with had a good understanding of safeguarding and gave us assurances they would report anything they were concerned about to the matron or local authority. There was little in the way of accessible, up to date information on how the home would report concerns but the registered manager told us they had signed up to the safeguarding champions training and this was due to begin soon. There was a safeguarding lead in the home who would disseminate any information they received from the local authority or safeguarding board. There was a comprehensive policy on safeguarding which had recently been reviewed and was due to be disseminated amongst the staff team.

We recommend the provider ensures all staff receive up to date safeguarding training to refresh their understanding

We saw appropriate risk assessments for the use of restraint including bedrails but we did see one person in a recliner chair without the appropriate assessment. The nurse we spoke with could talk us through the rationale and support this person required but this was still to be recorded within the care plan. The person told us they were comfortable in the chair. We were assured this information would be added immediately.

We saw the home assessed people's specific risks including, falls, nutrition and pressure areas. We saw these were reviewed monthly or as required. However some records were difficult to follow as they were written in a number of different places including in care rounding records, individual care plans and in other specific conditions files, including a wound and dressing file, weights file and falls logs. We saw these were written in daily and the information was used during handover from one shift to the next. This ensured people were kept safe but records were cumbersome at times. We spoke with the registered manager about this who told us they were reviewing the paperwork to consolidate some of the records.

Accidents and incidents were recorded as they occurred and the records were reviewed by the registered manager. Monthly reviews of all accidents and incidents led to specific actions to ensure people were kept safe. This included the referrals of people to the falls team if they had fallen more than twice in one month. The provider needed to ensure the falls recorded on the accident records were also recorded on the person's individual falls log to ensure their specific assessments were kept up to date. We did see the

information was recorded in people's daily records and was handed over from shift to shift to ensure people were monitored after a fall.

The home had a number of risk assessments for the building and environment including the kitchen and a fire risk assessment. Risks were monitored daily, weekly and monthly by the maintenance person and included the testing of fire equipment, water temperatures and the operation of profiling beds and mattresses. We saw a system of managing the safety of the building which included recording in a maintenance book any issues and the use of contractors if required. We also saw the professional testing of equipment took place as required.

The home had a contingency plan which had recently been reviewed and included the management of major incidents including fire. The registered manager was in the process of adding the relevant contact details to the plan over the course of the inspection. People had individual assessments for their Personal Emergency Evacuation Plan (PEEP) and some of these were to be reviewed shortly.

On the day of the inspection we reviewed the personnel files for six staff. We found all the required checks had been completed and everything was available in the files to show staff had been recruited in an equitable, fair and transparent way. We saw the required DBS checks and references were in place to help determine that staff were safe to work with vulnerable groups. We saw staff completed an application form and interviews were completed and scored for successful candidates.

A nurse specialist advisor supported the inspection who reviewed the home's procedures for the administration and management of medicines. We saw the nurse administering the medicines prioritised people who needed to take their medicines at specific times and with food. We saw medicines were given in a dignified manner and people were told what the medicines were for and had the opportunity to refuse them. The nurse we observed assessed the requirement of PRN (as required medicines) before they were given and recorded the assessment.

We looked at the available MARs records in detail for six people living in the home and found they were complete and included detail of the person's medicines and how they should be taken. There was also a picture of the person and any known allergies were recorded on their MAR. There was a record of staff signatories and a record of how they would sign the MAR so staff could be held accountable for any errors.

On the day of the inspection, medicines were stored appropriately and were all in date. We reconciled medicines including controlled drugs and all were correct. We saw dates were written on bottles and cartons when opened and all were destroyed before their expiration date.

Controlled Drugs were stored in line with regulations and the register was accurate and audited twice daily. We did however note there was a stock of controlled drugs that had been dispensed in 2015 and not been used for over a month. We discussed this with the nurse who assured us that those medicines that required destroying would be dealt with as a matter of urgency. We also noted that the staff were only recording the maximum daily temperature on the medicines fridge and both the minimum and maximum temperature was to be recorded going forward.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us the staff were excellent and were equipped to meet their needs. One person told us, "They [the staff] are very good, they look after us. They encourage me to do more for myself and help me when I need it." Another said, "I think the staff know their job, whether they are qualified or not, I don't know, but they do the job well."

Every person we spoke with told us the staff would phone for a GP if it was needed. One told us, "If staff think I am unwell, they will send for the doctor." One family member said, "They keep me informed how they are looking after [relative]. They have the doctor out straight away if they are needed."

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. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found there were eight historic DoLS applications which had not been authorised. People entering the home had not routinely had their capacity assessed and DoLS applications had not been made when required.

When we looked in people's care files we did not see that the MCA guidance had been implemented. There were no capacity assessments for people for any decisions that had been made on their behalf. It was clear some best interest decisions had been reached to keep people safe but these had not been recorded as such and lacked the detail to ensure they were done within the principles of the MCA.

We saw the home had assessments for restrictive practice including bedrails, lap belts and recliner chairs. We saw these were in all but one occasion signed by family members. We could not identify a clear rationale for this. We also saw a number of records for consents, including consent to self-medication, care and treatment and in agreement of the care plan. Again these were predominantly signed by family members.

We observed how staff gained consent on a day to day basis and continually saw staff seeking consent before delivering any interventions. People were asked where they wanted to eat their meal, where they wanted to sit in the lounge area and if they wanted to be involved in the arranged activities.

We spoke with the registered manager and staff in the home about the Mental Capacity Act and consent. We specifically asked why family members had given consent and not the person themselves. We were told by most staff that family members agreed and signed for things when the person wasn't able to communicate what they wanted.

We spoke with the registered manager about this who acknowledged there was more learning required in this area. At the time of the inspection the home were not applying the principles of the MCA and consent was not always lawfully gained as a direct consequence. This is a breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We observed how staff and people in the home interacted and saw staff responded to people's needs. However we saw there was a delay in this when two staff were required as identified above.

Staff we spoke with told us they were supported well by more senior staff. The home had a trainer who delivered training every week, twice a week. At the moment this training was focused on implementing the updated policies and procedures in the home. Staff told us in the past this training had included moving and handling and safeguarding. The trainer was on annual leave on the day of the inspection so we could not ascertain the most up to date training schedule but we could see there were some certificates ready to be distributed in their filing cabinet.

We recommend the trainer ensures the training matrix is kept up to date to allow them to determine the appropriate and required training to be delivered to ensure mandatory training is completed as it should be.

We spoke with two staff that had recently started at the home and they described a comprehensive induction. This included time shadowing other staff members and a period of time of competency testing their abilities to support people independently.

We saw there were team meetings and staff signed the meeting minutes in acknowledgement of the content. We also saw that staff received an annual appraisal. However we did not see any evidence of clinical supervision or competency testing of clinical tasks. The registered manager assured us this was something they were looking into. Some clinical staff had recently received theoretical training in venepuncture (puncturing of the vein, either to take blood or to insert a cannula for the delivery of medicines) but their competency in the practical task required to be signed off prior to them undertaking the task. Clinical staff may also benefit from specific training around the clinical conditions as supported within the home. For example, pressure area care, PEG (Percutaneous Endoscopic Gastrostomy care and catheter care. To note we did not identify any real concerns in the delivery of this care but investment in the clinical team could only benefit the people living in the home as staff would be more confident in these areas.

In the care plans we looked in we saw people had been suitably assessed to ensure they were in receipt of enough nutrition and hydration. People were routinely weighed once a month and when risks were assessed this increased as required. However we found that these records were not always collated to ensure effective and timely action was taken. For example, at times weekly weights were recorded in the diary and not used to inform and update the care plan until sometime after. We discussed this with nursing staff and the registered manager and were told there had been a problem with the weighing scales for the last few weeks and they were not confident of the readings. We found staff were using the scales in different places around the home and senior staff thought this was impacting on the recorded weight. We were told staff were to start taking people to the scales to be weighed to reduce the risks of inaccurate recordings.

We looked at the records used to monitor the food and fluid intake for people in the home. We saw that everyone's diet was being monitored. We found records were poor and did not reflect what people had actually eaten. For example, one person was observed at lunch time on the day of the inspection eating very little of their meal, yet the monitoring recorded that they had eaten three quarters of their meal. We

discussed this with the registered manager and agreed that potentially as everyone was having their intake monitored, this deflected from the needs of the few people that needed their food to be monitored. The registered manager told us they would consider if there was a better way of doing this.

We noted one person appeared to have lost 6 KGs in one month but the nurse weighed them again on the day of the inspection and found this was not correct as their weight remained similar to the previous recording and it was unlikely they had lost and gained the same amount of weight in a month.

We spoke with the chef about people's diet and the information they had to support people. We were told an accurate account of the special diets people had including those that required their food to be pureed and fork mashable. The chef was not given any information about people's food preferences when people first came to the home but the chef had recently completed a survey to gather this information. Food was discussed at residents' meetings and people we spoke with were all happy with the food available at the home. We asked how the home was fortifying foods for people that were losing weight and were told they were using margarine, we discussed the benefits of margarine and were assured the home would invest in butter to fortify diets.

We saw the home made referrals to the Speech and Language Team (SaLT) and dietician when required and that they followed the plans of care they were given as a result of any professional assessment. Care plans were developed and reviewed monthly and any associated risks with people's nutritional intake were discussed at handover. This included prompts to give people food in between meals if they had not eaten much that day.

Professionals visited the home to support the people who lived there. We saw records from district nursing teams and tissue viability teams. We also saw referrals to a number of external professionals, including the hearing and optician clinics. On the day of the inspection we spoke with a visiting nurse from the community neurology team. We were told the home worked well with them and would ensure the patient was ready for them when they arrived. The team were soon to start handing over some therapies to the staff at the home and they were confident that with competency testing, the staff would continue to deliver the required support.

Good

Is the service caring?

Our findings

People we spoke with who lived in the home had praise for the staff and all they did. Comments included, "Staff are good and polite." "Staff are excellent, I love all the staff." Staff are respectful to me and call me by my name." "The staff are very good and they really care for you" And, "I wouldn't want to be anywhere else."

People told us there was plenty to do and staff took the time to get to know them when they could. We saw people had access to the things they liked including the community and daily papers. People told us they could go to the church if they wanted to and that visiting clergy came to the home. We could see when staff interacted with people, they cared about the person they were talking to.

No one we spoke with told us they sat down with staff and specifically went through their care plan and three people told us they would like to do this. We noted from the consents to care and treatment forms we looked at that this should have been happening every six months. We would recommend the provider take steps to complete this piece of work if people want to be involved to that extent.

Each person had a designated keyworker who took the time to get to know people more personally. People we asked knew who their keyworker was and we saw notes were kept of keyworker tasks. Keyworkers ensured people had enough toiletries and were happy with taking part in the scheduled activities. They also ensured people were happy with the way their food was presented.

In every bedroom we looked in, we could see the person had personalised it to their taste and included ornaments, pictures and even furniture of their liking and choosing. Everyone we spoke with was very happy with their room, one person told us they felt like they had a flat not a room, as it had everything from a fridge to a TV. The home supported people with things that were important to them and we heard stories about staff ensuring important pictures were framed and people had the correct wool to be able to complete a specific knitting pattern.

We saw everyone was treated well and their dignity was respected. All the toilets had dignity locks and all staff knocked on doors before entering anyone's room. All the clocks in the home told the right time, which helped keep people in the present. There were notice boards with information on about activities, the daily menu and outside weather conditions displayed around the home.

We saw that predominantly if people wore glasses they had them with them and a number of people had their own hoist sling for their personal use hung on the back of their bedroom door. This showed us the home took care to ensure people had what they needed to keep as independent as possible. People told us the staff encouraged them to do as much for themselves as possible.

Everyone in the home looked smart, clean and well presented. We were told that keyworkers undertook personal activities with people including cutting and painting finger nails. The home had a hairdressing salon and people told us how they enjoyed visiting it each week.

When we spoke with visitors about any restrictions it was clear they could visit any time they wanted and were made welcome by the home. We saw visitors being offered cups of tea and tea being presented to people when they requested it, rather than having to wait for a particular time. There were jugs of water or juice in people's rooms and we saw drinks were available at all times.

We saw in the keyworker files a set of questions for new workers to go through with people to get to know them and their past life. This enabled staff to build relationships with people not just based on their needs and showed the home took the time to get to know people as the person they were, prior to coming into the home and needing support with their daily lives.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about how they spent their days and were told about a number and choice of activities including one to one time with individual staff. One person told us, "We do activities including bingo and carpet skittles." Another told us, "I get out and about and go to the local shops on my own, they weren't sure at first but now they know I'm safe and as long as I sign in and out they are fine." People told us of trips to the sea and trips out to get fish and chips.

People had care files which held their specific care plans, assessments, professional and specialist support and monitoring records and the home used supplementary files, which held the detail around, people's weights, wound care and personal hygiene records. We also saw a large amount of resident information was also recorded within the daily diaries available on both floors and handover records. It was clear the home recorded and responded to people's needs comprehensively. However not all of this information updated the care file on a daily basis. We discussed this with the registered manager who told us they were looking into how they could streamline paperwork to make things easier and ensure things were not missed.

For example, we looked in detail at the bath and personal records held in the bath file. We saw that some people did not have a record of receiving any personal care for up to four weeks. On the week of the inspection the ground floor records had not been completed for up to five days. The registered manager told us there were new staff starting at the home that were shadowing and did not write in the records. On the day of the inspection the registered manager was needed to update the records and show the new staff how to complete them. This reinforced the need for more staff to ensure the records were kept up to date and all information was included within peoples care files to update the assessments and care plans as required. It was clear from looking at people living in the home that they had received regular personal care.

We looked at the records of extra care monitoring including monitoring of people's food and fluids and of the turns people required to reduce the risk of pressure areas. We found records were poor. We reviewed the care management information around pressure areas and whilst we could not find any evidence to support issues had worsened for anyone as a result of not being turned, the required records were not available to show people had been turned in line with their care plans.

We found a lack of appropriate recording of the required information to ensure people's assessed needs were met and a lack of collation of the available information to allow for assessments to be updated in a timely way a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We found the home had a comprehensive policy for the handling of complaints. We saw records of complaints were kept and a flow chart was in place to support the correct procedures were followed. We looked at two complaints in detail and saw the procedures highlighted within the home's policy were followed. There was an available complaints procedure on the wall in the main foyer and people we spoke with knew how to make a complaint if they needed to.

The complaints we reviewed were responded to in a timely manner and people were given copies of the procedure at point of complaint. Meetings were held with complainants to ensure they were happy with the process and outcomes and we saw information on improvements was shared with the staff team.

However the information on the home's complaint leaflet reflected the old CQC regulations and required updating. We recommend the provider updates the procedure to reflect the regulated activities regulations 2014.

We saw a number of activities on the two days we were at the home including bingo and some singing. Everyone seemed to enjoy themselves and we saw friendly banter over who won the bingo. People told us they were happy with how they spent their day. We saw people coming in and out of the garden and there was a shaded area for people to keep out of the sun if they wanted. We saw staff reminding people to wear a sun hat and wear sun cream if they were going to sit out in the sun.

In the care files we reviewed, we saw people had a social profile which included key life events. At the time of the inspection we saw the apprentices working at the home were in the process of completing information on people's preferences. We saw each file had a person centred approach to their care plans including each person having a detailed sleep and night time routine. Every person had a daily review completed, which whilst primarily task focused, did also include details of each person's mood on any particular day.

We discussed with staff the priorities of their day and it was apparent it was the delivery of care and support to the people who lived in the home. We could see care plans were all reviewed monthly but there were some bigger gaps in the assessments for people. We also found where people had fallen in the last month, not all the associated falls log and associated risk assessment had been updated. However we could see they had been referred to the falls team and steps had been taken to reduce the risk, including the introduction of a lap belt for one person to their wheelchair to help reduce the risk of them slipping out.

It was clear from reading records that a system had been developed to ensure the information was gathered and used to inform the delivered care and support to people. A lack of staff had resulted in a lack of time to complete the required paperwork. Strategies had been introduced to meet specific identified needs including referrals to external professional teams, increased monitoring of weights, which had all been clearly defined within the plans of care.

There was evidence of appropriate action being taken at point review including those undertaken by the person's GP. We saw one person had been reviewed and the doctor had made adjustments to the person's medication. This had immediately been reflected in the person's care plan and prescription. However, we also noted a request for this person's blood pressure to be monitored monthly and there were no records of this within the care file. We were assured this had been done.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had been registered with the Care Quality Commission since 2011. They were previously registered with the Commission for social Care Inspection in 2009. Staff we spoke with enjoyed working at the home and all said they were supported well by the registered manager and other staff.

We saw the home had a standard set of monthly and quarterly audits which included monitoring the managing of medicines, training and equipment, the condition of the kitchen and care plans. We saw actions were developed from the audits and staff and the registered manager agreed timescales for the completion. Audits were then reviewed to ensure the actions had been completed. We noted some audits had not been completed for a couple of months and this was due to the registered manager working more out on the floor to meet the needs of people living in the home. A lack of staffing had led to the registered manager being unable to complete the audits as required to ensure the safety and quality of the service was maintained, this has had an impact on the quality as identified within this report. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We saw monthly monitoring records were reviewed to identify themes and trends and this included accident and incidents including falls. Reviews led to actions including the referral to specialist teams and the introduction of increased monitoring of people's care needs.

We also saw there were weekly management reports shared with the provider and senior staff and a bi annual health and safety report identifying any areas of development and required improvement.

Staff employed at the home were encouraged and supported to complete a care specific qualification and the home worked with the local college supporting those completing care specific qualifications through offering apprenticeships. We saw that all staff were treated equally with them all receiving an induction and required attendance at the weekly training sessions.

The home had champions who led on areas of care including, safeguarding and dignity. We saw the home had a developed ethos of promoting the welfare of people living in the home. This was evidenced through the team meeting minutes of the different staff groups. We saw issues were discussed and people's independence was promoted. Staff commented on the rehabilitation of people following falls and broken bones and we saw this was monitored through the daily handover records.

The home had a large set of policies and procedures which had recently been reviewed. We saw staff were being introduced to the changes in policy through the weekly training sessions. Staff were aware of the whistle blowing procedures and were confident to report concerns to the management.

The registered manager regularly worked on the floor. Due to staff shortages this had increased recently. People living in the home all knew who the registered manager was and staff felt comfortable working alongside them. Staff, visitors and people who lived in the home all told us the registered manager was

approachable and were confident they would deal with any concerns if they were identified.

All staff at the home, including clinical staff, caring, domestic and catering staff all told us they had all the equipment they needed to perform their role. The maintenance team told us if they needed to replace any items within the home or there were any repairs that were required they would be authorised to complete them.

Feedback was sought from people living in the home on a regular basis and included feedback from residents' meetings and the collation of the results from annual audits. Certain sections of the home including the activities coordinator and chef asked for feedback more regularly. Feedback from people and their relatives was predominantly positive and the results of any questionnaires and surveys were available in the home's foyer. We also saw a number of thank you cards from friends and family showing appreciation for the home and its staff team.

The home had a welcome pack which was available in the foyer and provided to all new people to the home. The pack included details of the services the home offered including activities and hairdressing. The pack also included key information on how to make a complaint and the management structure within the home. There were leaflets in the foyer about a number of relevant support groups and details of last CQC report.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (5) Care and treatment was not always provided with the consent of the relevant person. The principles and code of conduct of the Mental Capacity Act 2005 were not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 (1) (a) (c) (e) The laundry and some storage spaces were not clean, There was not the required equipment for the management of clinical waste or soiled items where needed and some equipment was not stored or used appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (c) There were gaps in the way the service had been audited and monitored which had an impact on the quality of provision. An accurate, complete and contemporaneous record was not kept in respect of each service user.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Regulation 18 (1) There were not enough suitably qualified staff to meet the needs of people in a timely and appropriate way.