London Borough of Haringey

Osborne Grove Nursing Home

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 and 7 December 2016 and was unannounced. The inspection was prompted in part by notification of an incident where a person sustained an injury and information that moving and handling equipment had been out of use for twenty days. The information about the incident indicated potential concerns about the management of the risk of falls from moving and handling equipment. This inspection examined those risks.
The previous inspection was in November 2015 and at that time all legal requirements were met. We made recommendations at the previous inspection to improve care plans, activities and stimulation for people living at the home to ensure that people's needs were met proactively and responsively. There had been some improvement since that inspection but not enough to ensure people's needs were always met.

Osborne Grove Nursing Home is registered to provide accommodation and nursing care for up to 32 older people. The home had a registered manager in place however they were on extended leave at the time of this inspection. 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. An interim manager started the day before the inspection. This person had worked at the home for several weeks in a different capacity so had some knowledge of it. There was also a "supporting manager" who was working at the home temporarily to assist with a plan of improvements.

At the time of this inspection there were 24 people living at Osborne Grove in three eight-bedded units. The fourth eight-bed unit was closed and no further admissions were planned at the time of the inspection.

People living in the home told us they were happy with the care and had good relationships with the staff. The visitors we met were generally happy with the care too.

People said staff were friendly and polite and they felt well looked after. There was mixed feedback about the food; some said it was good and others said it lacked variety. We also found a lack of choice, and people who were supposed to have fortified meals and extra snacks were not always receiving these.

Most people said they had nothing to occupy them during the day though some were happy to stay in their rooms. We found there was a lack of activities and opportunity to go out for people. There was a full-time activities coordinator but the provider had used them for other duties. They were returning to their full-time role at the time of the inspection.

The moving and handling equipment (hoists) had been out of action for twenty days just prior to the inspection. The equipment had been checked for safety and was working and in use at the time of the

inspection but most people had to stay in bed for twenty days which contributed to one person developing a pressure ulcer. Appropriate action had been taken relating to the accident using a hoist to prevent a similar accident happening.

There were breaches of seven regulations at this inspection. This was because we found improvements were needed in the areas of medicines, equipment, food, assessing mental capacity, support for staff, governance of the service, person-centred care, and making notifications to us. 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?

Inadequate

The service was not consistently safe. People's medicines were not always managed safely. People had individual risk assessments to identify risks and manage them but some risks had not been adequately managed leading to one person developing a pressure ulcer and others losing weight.

Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred.

Call bells were not working in some rooms leaving people unable to call for help. Equipment was not always checked promptly when due for inspection.

There was no evidence of regular checking of nurses' registration to ensure they were still registered.

There was no assessment of staffing needs for the home so we could not confirm there were enough staff to meet people's needs . There were vacant nurse posts.

The home was clean but we found a lack of soap in many rooms on the first day of the inspection which was an infection control risk.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff received appropriate training for the job but did not receive enough supervision and support.

The service did not follow best practice in encouraging people who were able to, to get out of bed every day.

People received effective support to meet their health care needs from external professionals such as the GP, dietician and tissue viability nurse.

Some people's nutritional needs were not fully met as those who

needed fortified diets to combat weight loss were not receiving them. There was not enough choice of food for breakfast and evening meal.

Staff understood people's rights to make choices about their care and there was some understanding of the requirements of the Mental Capacity Act 2005. There was a lack of capacity assessment for a person whose money and other personal items were looked after by the service.

Is the service caring?

Good

The service was caring. People living in the home praised staff and described them as polite and friendly. People said they felt well cared for. Staff had formed good relationships with people and treated them with respect. People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plans were not always person-centred. People had limited opportunities to have a shower or bath. People said they did not have enough to do. There were some activities but not enough to meet everybody's needs. This was due to the activities coordinator having to take on alternative duties. There were plans to improve these concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The manager was on extended leave at the time of this inspection and an interim manager had started that week so this was a time of change and uncertainty for the service. The provider had not overseen the running of the service effectively. Auditing in the home was not robust enough. The provider and registered manager did not always make the required notifications to us.

Osborne Grove 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 (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 6 and 7 December 2016 and was unannounced.

The inspection team consisted of one inspector for both days, a pharmacist inspector (one day), a specialist professional advisor who was a nurse (one day), a specialist professional advisor who was an occupational therapist (one day), a bank inspector (one day) and an expert-by-experience (one day). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This person's area of expertise was dementia care.

Before the inspection we reviewed all the information we had about the service. This included last year's provider information return, notifications, concerns and safeguarding alerts, and information from the local authority and Clinical Commissioning Group (CCG).

We met all 24 people living in the home. We talked individually to ten of them. We spoke with a relative or friend on behalf of four people. We spoke with the interim manager, the 'supporting manager', three nurses, a cook and the activity coordinator. We met thirteen care assistants during the inspection as they were carrying out their work and spoke with three individually. We visited at 6am on the second day of the inspection to meet the night staff and observe the early morning routine. We observed the morning handover where the deputy manager shared information and allocated staff to each unit for the day. We also met with two visiting healthcare professionals and a local GP during the inspection.

We carried out pathway tracking for five people. This involved reading their risk assessments, care plans and

the records of care provided to them, talking with them and observing staff interacting with them. This helped us see if people's assessed needs were being met.

We observed staff interacting with people in the communal rooms and in people's bedrooms. We observed mealtimes on all three units. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being. We used SOFI with individuals and small groups of people in the unit lounges.

We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies for 16 of the 24 people in the home.

We looked at six people's care records, food and fluid charts, continence charts, repositioning charts, activities records, menus, health and safety records, staff training and supervision records, the policies and procedures available in the home, quality assurance records, records of staff meetings, residents' and relatives' meetings and records relating to fire safety and maintenance of equipment. We also looked at five staff files in detail.

We inspected the building and all the equipment used to help people move around within the home.

Inadequate

Is the service safe?

Our findings

When asked if they felt safe in the home people said, "Yes, knowing there's help at hand", "I feel very safe" and "Yes...it's secure here. Safety is paramount."

Staff understood the different types of abuse and senior staff knew how to raise a safeguarding alert. The procedure to follow if anyone had any safeguarding concerns was displayed in the lift.

Prior to this inspection there had been a safeguarding alert raised as there had been an accident in the home where a hoist was not used safely and the person sustained an injury.This was under investigation at the time of the inspection. There had also been a concern where the hoists in the home, which are used to help people move were a few weeks overdue for their six monthly professional safety checks. Staff had been unwilling to use the equipment until the six monthly safety checks had been carried out. This had led to the majority of people in the home being confined to bed for twenty days whilst they waited for the hoists to be tested. This put some people at risk of physical harm arising from inability to move and was also a breach of their human rights. Although the registered manager had taken steps to ensure most people changed position within their beds regularly to reduce the risk of developing pressure ulcers, this was insufficient action overall to ensure the safe care and treatment of people. The registered manager had reported this situation to their line manager in the London borough of Haringey but the provider had not resolved the situation for twenty days. This came to our attention on 30 November and was resolved by the provider on 2 December.

People had risk assessments in their files to inform staff of the risks to their health and safety and what action was needed to minimise the risks.

As most people were unable to walk or move around without assistance they had a risk assessment to assess their risks of getting a pressure ulcer (this is called a Waterlow assessment). They then had a care plan detailing any pressure relieving equipment they may need and for how often they would be supported to change position depending on individual risk. One person had a care plan stating that they should be supported to change position every two to three hours. We checked five days' records for this person and found that for three of those days they had stayed in bed in one position for most of the day. On some occasions staff had recorded that the person declined assistance but on other occasions there was no record to explain why they were not helped to move position. This lack of movement put the person at higher risk of developing a pressure ulcer.

Another person was assessed as being at high risk of a pressure ulcer. A week's worth of records for them showed there were periods ranging from 8 to 16 hours overnight where staff had not recorded that they had helped this person move position. In addition this person had not been on a pressure relieving mattress at that time. Staff said this was because the hoists were out of use so they were unable to lift this person in order to change their mattress but this person was at high risk and should have had a pressure relieving mattress in place before the hoists were out of service. As a result of not having the correct equipment to help them move and not being helped to change position regularly enough, this person developed a grade

three pressure ulcer. Staff requested specialist assistance about this ulcer and the healthcare professional came to visit to advise on correct treatment during the inspection.There had been a failure to provide this person with safe care and treatment.

Each bedroom had an en-suite toilet and there was one bath and one shower for each unit of eight people.The communal bathrooms had adaptive equipment to make bathing easier. In two of the bathrooms however, the adaptive bath had not been serviced since November 2013. Service checks are normally due every 6 months for this equipment. This meant the baths may have been unsafe.

Most people had hospital type beds of adjustable height, and pressure relieving mattresses. Most beds and mattresses appeared to be working and had up to date service records but one air pressure mattress service had not been serviced according to the service label since June 2014. With three other beds, it was not clear from the service label when their air mattresses had been serviced or when the next service was due. Another bed was bleeping both days of the inspection as there was low pressure in the mattress. This had been reported but was not yet resolved. We found the mattress to be only partially inflated which was a risk to the person as they were unable to leave their bed for medical reasons so relied on this pressure relieving mattress to prevent pressure ulcers. This left the person at risk.

There was no system in place to manage alerts from the Medicines Handling Regulatory Authority (MHRA) who notify care providers when there is a concern about equipment or medicines which need to be taken out of use. This meant there was a risk of staff using equipment that was no longer appropriate.

Radiators were fitted with guards. One radiator had a broken guard which was not safe as the person could be exposed to a hot radiator.This was a failure to ensure safety for this person.
The guard had been ordered. We asked the supporting manager to take interim steps to ensure this person could not come into contact with the hot radiator and they agreed to do so.
A number of people had no call bell or a broken call bell on the first day of inspection. We heard a person calling for help twice and had to find staff to go and assist. One person told us, "Sometimes the buzzer doesn't work...I ring the office (from their mobile phone); it's better than panicking!" The interim manager took action immediately this was brought to their attention, to call an engineer and to give call bells to some people from the empty unit.

Some bed bumpers had worn fabric and so had become an infection control risk along with one recliner chair which had a tear in the fabric. Kitchen cupboards in the units had their covering peeling off which was not hygienic or homely.

The fire alarm was overdue for inspection. Staff had been testing it monthly but this had changed to six monthly with no reason recorded. The professional service had been due in November 2016.There had been a recent fire risk assessment with actions to be completed by January. We noted that one action regarding storage of oxygen cylinders had not yet been completed as there were eight cylinders, four of which were empty, not stored appropriately.

Medicines were not always managed safely. All prescribed medicines were available. A local community pharmacy supplied medicines to the service on a monthly basis. Most tablets and capsules were dispensed into a monthly monitored dosage system. Nurses recorded the date of opening appropriately on the other medicines.

There was no written protocol for medicines that were to be given as and when required, for example painkillers. The National Institute for Clinical Excellence (NICE) guidelines state that having a written protocol is good practice in a nursing home.

We saw a nurse mix two liquid medicines together with the aim of administering them via a percutaneous endoscopic gastrostomy (PEG) feeding tube. This is a device that allows a person to be fed directly into their stomach if they are unable to swallow food and drink. The nurse had not checked whether the medicines were compatible before attempting to mix them. This was unlicensed medicines use, had not been recommended by a prescriber and was unsafe. Unlicensed medicines use is when a medicine is used in a way that is different from that described in the license. A prescriber can decide that unlicensed use of medicines is necessary but this decision must be documented and it was not in this case. We also advised that it was best practice to give liquid medicines separately via a PEG tube, and flush the peg tube with water in between medicines.

In addition, we noticed that one of the liquid medicines was not written on the MAR chart. We asked the nurse to confirm whether the medicine was still current, and it was. It had been missed off the MAR chart which indicated that the charts had not been checked the previous day to ensure they were correct. There was a risk that this prescribed medicine would not have been given.

There were no topical MAR charts so staff would not necessarily know where to apply creams, ointments and patches. In addition, they would not know whether application sites for patches had been rotated appropriately. A nurse told us that care assistants were given verbal instructions on where to apply creams. There were avoidable risks associated with this practice.

We saw that staff were using a laxative medicine for current people using the service, despite it being prescribed for a person no longer at the home. This practice was against the medicines policy for the home.

If a variable dose of medicine was given for example one or two paracetamol tablets, staff did not record the exact dose given. This meant, nurses may not always know how much of the medicine the person had taken that day.

We saw a nurse crush a tablet and give it to a resident with water and a thickening product. However, there was no information available to suggest that it was safe for this to be done. Again this was unlicensed administration of medicine, and there was no formal agreement from the prescriber that the nurse could do this. Staff did not know whether the blood sugar monitoring testing kits were being calibrated appropriately. We did not see any records of this activity.

On the first day of the inspection there was no soap in a number of rooms including bathrooms, toilets and kitchens and the laundry room. Instead of using the wall fitted soap dispnsers the service was using bottles of handsoap. Most of these were filled when we raised this concern. A healthcare professional also told us there was no soap available when they had previously visited. A lack of suitable handwashing facilities is an infection control risk.

All the above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The minimum staffing was six care assistants for twenty-four people at any time of day or night (a ratio of one staff to four people) plus two nurses during the day and one nurse at night. There were domestic staff, a cook and an activity coordinator during the day. Some days there were more care assistants on duty. We

were unable to assess whether the staffing levels were sufficient to meet people's needs as there was no dependency assessment to show how many staff were needed on each shift. The majority of people required two staff to help them change position, wash and get out of bed using hoisting equipment. The majority of people also needed staff support to eat and drink. Nurses had been given extra responsibilities in addition to their nursing duties, supervision of care assistants and being in charge of assessments, care plans and risk assessments.

One person living in the home told us, "There's never enough staff. They're quite high dependency on this unit and they need more staff. Some people need feeding, so getting ready in the morning can be very late or very early." Another person said they sometimes had to wait a long time for their breakfast. Some staff said they thought there were enough staff on duty but one said it was not possible for staff to assist every person to get out of bed and come to the lounge every morning. Staff worked in twos to assist each person with their personal care in the morning so helping eight people took a considerable time.

Medicines training was delivered to all nurses and some care assistants. Care assistants were also trained to administer topical preparations. There were no missed doses of medicines on the MAR charts and each person had any allergies recorded appropriately on their MAR.

We checked the building (except the empty Magnolia unit) for safety and cleanliness. At the time of the inspection all mobile hoists had been assessed as safe and were being used to help people get out of bed. We checked that staff had been trained in using the equipment and we observed two staff using the standing hoist to transfer somebody. We were satisfied that the staff used the equipment safely. The week after the inspection staff also received further refresher training in use of hoists.

Some people had their own sling for the hoist which was the correct size for them and was stored in their room. Other people shared slings but there was no system in place to ensure prevention of infection. . We saw one disposable sling without packaging, which may have been used. It was not possible to identify who the sling belonged to because it was not labelled. A staff member said the sling should have been thrown away because it appeared used. The staff member immediately put the sling in the bin. Staff were unable to confirm the exact number of hoist slings in the home and there was no inventory record but the majority of people did not have a sling for their sole use.

We checked all of the ceiling track hoists in the communal bathrooms and these were in good working order, but two located in bedrooms were found to be not working and one ceiling track hoist service sticker log was out of date showing the service was five months overdue. A member of staff said a service request had been made, but could not confirm when the service would take place. Staff said people with faulty ceiling track hoists were being transferred using mobile hoists instead. We were unable to locate any ceiling track hoist slings and therefore could not confirm if the slings used were appropriate for the hoist or whether other hoists were always used in preference to the ceiling track hoists.

The three mobile hoists had been serviced recently. When tested on the second day of the inspection, one hoist worked but two were not working. This may have been because their batteries had not been fully charged. Standing hoists were in good working order.

People did not have their moving and handling care plan in their rooms but staff reported they were able to transfer people safely, because they were familiar with people's care plans and risk assessments.

We observed two staff help a person move from room to room using a standing hoist. The hoist transfer was completed successfully and safely.

We recommend that people are supported to obtain their own sling for a hoist to be kept in their own rooms. This will reduce the risk of an incorrect size/type of sling or a dirty sling ever being used.

Most furniture was safe and clean. The home was generally clean and tidy despite cleaning schedules not being completed. Cleaning schedules were displayed in toilets only.

Staff wore protective clothing when supporting people with personal care to minimise the risk of infections being spread in the home.

There were personal evacuation plans and a fire procedure to follow in the event of a fire. There had been a fire risk assessment undertaken in 2016 to highlight fire risks and an action plan to address them. The emergency lights and lift had been recently serviced. Fire procedures for staff were comprehensive and clear. Some staff were trained as fire marshals and most others had completed fire safety training.

There were staff vacancies as three of the nine nurse posts were vacant. There was no dependency analysis to determine how many staff were needed each day to meet people's needs. We recommend that a dependency analysis be undertaken using a recognised tool to determine the staffing levels needed and to ensure current staffing levels are sufficient. The supporting manager told us there were plans to recruit new agency nurses. We checked five staff files and found evidence that they had been vetted as suitable for their role. Two nurses' files showed their registration had expired. Both said they had renewed it but their files had not been updated.

Requires Improvement

Is the service effective?

Our findings

People did not always receive effective care based on best practice. Some people got up every day and some got up for a few hours a day. Others spent more time in bed. The majority of people stayed in bed on the first day of the inspection. We checked six people's records to see how many days they got up. Not counting the twenty days when most people were unable to get up as the hoists were not in use, most people only got up for a few hours each day and some not at all for a few weeks. There was no clear recorded reason for these people not getting up. Two people told us they thought staff were too busy and that they didn't want to be "a nuisance" as it took two staff and a hoist to help them get up.

One person had a medical reason why they needed to be in bed all the time but there was no recorded reason why most people could not get up every day and take part in normal activities such as group meals, watching television and spending time with others. One person's care plan said they should be encouraged to sit in a chair for a few hours every day but daily records showed they did not do so.

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

On the second day of the inspection we noted staff assisted more people to get up. Two people told us they were happy to be up and out of their bedrooms. One said they enjoyed watching TV and the other said they liked seeing different people. At the end of the inspection the supporting manager told us they wanted to get 99% of people out of bed every day, which was encouraging.

Staff completed training relevant to their job so that they had the appropriate skills. There had been regular meetings with staff but less frequently in the last two months. Some staff had received regular supervision but others had not.
There was a lack of clinical procedures to guide and support nurses in their clinical decisions. There was no procedure relating to pressure ulcers so nurses relied on their own training and knowledge.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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 are called the Deprivation of Liberty Safeguards (DoLS).

People said they were able to make choices about their care. We observed staff seeking consent before providing care to people. There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Staff had received training on the MCA and DoLS. After the inspection the supporting manager told us that thirteen people had a DoLS authorisation. We had not been informed of these as is required. We found that some staff had not understood mental capacity assessments fully as

they had indicated that a person understood the information then concluded that they lacked capacity. This was raised at the last inspection with the provider manager (who was interim manager of the home at that time) but we found the same issue at this inspection. We found one person was having their access to their money, cigarettes and alcohol restricted but there was no evidence that they had been involved in that decision and consented to it nor that any best interest process had been followed if necessary. This meant the person was subject to restrictive practices without following the principles of the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three examples where a person had been assessed as lacking capacity to make a decision and saw that appropriate people were involved in making best interests decisions for those people. These were completed properly. There was no evidence in the care plans we saw that people had been asked to give their consent to their care plans but in practice we did see staff seeking people's consent to care and explain things clearly to them, for example, what would happen when they were in the hoist or what food they would be given.

People did not always receive appropriate support with their diet. There was mixed feedback from people about the food. One person said, "I'm on a puree diet....it's quite good." Another said, "It's not very good." Other comments included, "It's good. I can't complain. You eat what you're given and be satisfied with what you're given", "Good. It's eatable" and "The food is all right. I prefer to eat in bed."

The home had a four-week menu which was balanced and provided a choice of meals. However at the time of the inspection that menu was not being followed and the cooks were working on a temporary menu planned a few days in advance. The reason for this was that the home's usual food supplier was not supplying the home due to an issue between the provider and the food supplier. This meant that the manager had been going food shopping herself and the usual products were not available. The menu was therefore less varied and there was less choice for people. An example of this was for people on a pureed diet. They received meat, mashed potato and fresh vegetables for lunch then a different pureed meat, mashed potatoes and vegetables for tea every day. Everyone else had soup and sandwiches for tea every day. Some people told us they would like more choice. For breakfast porridge, cereal and toast was provided. Although the menu indicated cooked breakfast was available, in the past twenty four days this had only been cooked once and was scrambled egg. The main meal at lunchtime was a choice of two dishes. During the two days of the inspection lunch consisted of two choices of a hot main meal; on day one meat stew or meat pie and day two chicken served on the bone and fish fingers with boiled potatoes, mash and vegetables. People said the food was cooked well but some would like more choice.

There was a list of people on the kitchen wall who required a fortified diet to maintain or gain weight. We found that these people were not receiving a fortified diet. Dieticians had recommended extra ingredients such as cream of milk be added to their food to add calories. This was not taking place. The cook, supporting manager and a care assistant confirmed this. Many people had prescribed food supplements in the form of drinks. These were stored in their rooms but there was not a clear record of when they were offered/given a supplement. This was not recorded on the food charts that we looked at. A few people were losing weight and were not eating enough. We saw staff did encourage them to eat and drink and offer them extra snacks but this was not in a planned way. One person had not eaten or drunk enough for several days. Nurses had referred this person to a dietician and were encouraging them to eat but there was no clear plan for offering food, drinks and supplements at frequent intervals. A representative from the CCG visited during our inspection and advised staff to offer this person hourly drinks and snacks to encourage them to start eating again. Some people's MUST (a screening tool for assessing risk of malnutrition) had not

been updated in November. The nurses said this was because they could not be weighed when the home's hoists were out of action. There is an alternative way to measure a person's BMI but not all nurses knew this so it had not been done. There was insufficient oversight of the diet for people who were at risk of not eating or drinking enough. At one meal we saw two people being given half a banana each instead of a whole one each when one of them was supposed to be having fortified diet due to weight loss.

This amounted to a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was fruit and vegetables provided every day. People who had a PEG fed (where they were fed via a tube directly in to their stomach) were receiving their food as directed and there were clear written protocols for nurses to follow.

The supporting manager told us that the food ordering would return to the normal more varied menu the week after the inspection.

Staff completed a chart to record the amount of urine for some people where this was needed to monitor their health. The chart used also included bowel movements and the record could be confusing.

A number of local GP practices visited the home to see their patients. We met one GP who said the home was good and the nurses were competent and helpful. However, we noted that the extra work of liaising with several practices meant more work for nurses when ordering and collecting prescriptions.

Staff referred people to other healthcare professionals when they needed this such as dieticians, speech and language therapists for people who had difficulties with communication or with swallowing, tissue viability nurses where a person had a pressure ulcer and physiotherapists. Staff passed information to each other regarding people's health and welfare through their daily handovers verbally and though a communication book. We saw that a nurse told all staff that somebody was not drinking and needed encouragement and which people should be assisted to get out of bed.

Good

Is the service caring?

Our findings

People were happy with the staff in the home. They had formed good relationships with staff and those who had been in other homes all said that they preferred this home. People made many positive comments including, "There's a human touch and that makes me happy here", "9 out of 10. Very, very good...they treat me like a human being", "10 out of 10" and "8 out of 10 and the staff are pretty good."

Everybody who was able to speak to us said they felt well cared for and treated with dignity and respect. However, one person did say, "It's a very friendly place. They make up for any inadequacies by being friendly. The equipment went wrong and went out of service for a while."

People said they were made to feel welcome and one said, "It's a peaceful, harmonious and positive place."

During our observations of staff interacting with people over the two days, staff were very caring and attentive to people's needs. We saw some very good practice in supporting people to eat and reassuring people whose behaviour challenged the service by treating them with respect and dignity. With the hoist transfers, the staff talked the person through what they would like to do and gained their consent before proceeding then reassured them throughout.

People said of the staff, "They are polite and ask permission before doing things", "Yes, this is a good home...they're polite and kind" and "They're polite and friendly."

One person told us they were "grateful for the high standard. You could go to a private nursing place and not get the same standard of care. 11 out of 10, credit should be given where it's due at every level."

Another person said, "This place is like a five-star hotel in comparison to the other home I was in."

Relatives also said staff were helpful. We saw staff spending time talking to relatives.

Two people living in the home said staff were busy and hardworking and they would like them to have more time to sit and chat with them.

The home's normal practice was to leave everyone's bedroom door open. Nobody told us they were unhappy with this. We saw that staff always closed the door when assisting people with personal care to protect their privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

Each person had care plans advising staff on their needs and what support to give them. The six plans we saw did not show much evidence of people's involvement but people said they felt well looked after and two people told us they were involved in their care plan.

The home had a promoting-continence policy but it was not clear whether this was followed. Most people used continence pads and other than those who could move around the home independently, few people were being supported to use the toilet. A nurse told us that people did not use commodes or bedpans even though these were available. We did not see people being supported to go to the toilet.

Care plans showed whether people preferred a bath, shower or a wash in bed. Some people's care plans stated that they liked a shower every day or once or twice a week. Two people told us they did have a shower with staff support every day. However, we found very few people had a shower or bath on a regular basis. The baths had not been used for a while and were dusty and one bathroom and one shower room were used to store equipment such as hoists and wheelchairs. During the twenty day period when hoists were not in use the majority of people were unable to have a shower or bath. People were clean and staff told us that they always supported people to wash in bed every day but there was no recorded reason why many people were not having showers or baths for long periods of time. One person's care plan said they liked a shower but records indicated they had not had one for 23 days prior to the inspection. This does not indicate a person-centred approach.

People told us they liked the home, they thought they were well cared for and they liked the staff but most people said they would like more to do and that there was nothing to occupy them. Some were happy; "Yes. I like to be in here. I've got my pictures, my radios. I choose what I prefer to do and I have my friends and family who I speak to on the phone and they visit too." But another said, "There used to be entertainment: I can't create it."

People had individual activity programmes but these were not always carried out. A chat with staff was at times recorded as an activity. One person's activity record stated, "Had a one to one chat with a CQC officer" on the first day of the inspection. This was not an activity. There had been a trip to Capel Manor gardens in July but no organised trips since then. People also did not have regular opportunity to go out for walks to local shops, pubs or cafés.

There was a full-time activities coordinator but this person had been given other responsibilities in the home including administrative duties and supervising the domestic staff so was not able to devote their time to making sure people had something to do.

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

After the inspection the supporting manager informed us that the activities coordinator had had all their

other responsibilities removed so that they could carry out their activities role. This was positive. On the second day of the inspection a person offering pet therapy came to the home with their dogs to spend time with people who liked dogs. There had also been visiting musicians recently who planned to come regularly. The supporting manager told us that they were in the process of arranging for a mobile library to come to the home and had registered some people with the library.

There was an activities programme for the following week displayed in the home. This involved two people going out to a carol concert and lunch, a school choir coming to sing, poetry reading and carol singing and a Christmas party.

Some people enjoyed television and those who got up and were able to talk to us said they liked being up in the lounge.

The complaints book had one complaint recorded in 2016. There had been meetings with people using the service. We asked three people if they felt the service listened to their views and suggestions for improvement and they said that they did not feel their views about the food and lack of stimulation were responded to yet.
We did see the deputy manager and other staff welcome visitors and spend time with them, listening to their views and discussing their relative's care which was encouraging. When we told the supporting manager that one person was not happy with the food they took immediate action to listen to the person and resolve the concerns to make sure they received what they needed.

Requires Improvement

Is the service well-led?

Our findings

People living in the home generally thought highly of the nurses and care staff but didn't always think the home was well-run. One person said the best thing about the home was, "the friendliness and the good carers." Another person told us, "Yes to well-run but no comment on being well-managed." Some people did not know who the manager was but this may have been due to the registered manager previously having been away for a few months, and an interim manager being in place last year, plus two new managers starting in the home recently as interim manager and supporting manager.

There were no available recent or regular audits by the provider to check on the governance of the home. It is of concern the provider's own monitoring procedures did not find that people did not all have access to call bells for when they needed help. There was no evidence that the registered manager or the provider had oversight of the internal audits of medicines. We found that medicines audits were carried out regularly but action identified as needed was not carried out. For example it had been reported in an audit in September 2016 that many people's medicines MARs did not have their photograph attached but this had still not been completed. If new or agency nurses work in the home it would be very important that they can identify the right person to give medicines to by checking their photograph. Of the 16 MAR charts we checked, 13 had no photograph.

It was not evident that the provider had learned from the recent accident involving a hoist as although appropriate action was in progress relating to staff involved, there was a disposable sling in a bathroom which should have been disposed of. Staff did throw it away as soon as we pointed it out.

There had been a formal improvement plan in place for over a year but this had not been fully completed yet. The improvement plan did not address the concerns we found about a lack of personalised approach to getting up and use of baths and showers. There was a supporting manager from another service who was helping with the improvement plan. The current interim manager who started as manager the day before the inspection had also been in the home for several weeks assisting with the improvement plan. We were unable to meet individually with the interim manager as she was unavailable on the second day of the inspection but we met with the supporting manager and spoke with her at length. She was able to tell us of improvements planned in relation to infection control in the home, improving the food and getting people out of bed to make the most of their days.

For several months the home had not been allowed to recruit to the vacant nurse posts but the supporting manager informed us that the provider planned to employ new nurses shortly after the inspection to improve staffing levels and provide clinical leadership for the nurse team. Two weeks after the inspection the provider informed us that they had appointed new nurses including a senior nurse to provide clinical leadership.

Some staff had not had an appraisal in the last year and some had an appraisal but there was insufficient detail on the appraisal records to show that it had been a comprehensive appraisal. Staff were working hard but morale was low. This indicated that staff may not have been receiving enough support. Nurses did not

have access to written clinical procedures and at the time of the inspection had no clinical supervision. There was a reliance on the quality assurance nurses from the CCG to support and advise.

The failure to ensure hoists were able to be used at all times was a serious concern that contributed to avoidable physical harm to one person. The provider allowed the situation to continue for twenty days which was unacceptable and contrary to a person-centred culture.

People's records (other than their current files) were stored on shelves in an open office and storeroom which was not secure and did not keep their personal information confidential. The home's filing system was not efficient and staff were unable to locate a copy of the regulations during the inspection. A book of previous standards and regulations no longer in use was displayed in the foyer of the home.

We found two nurses's registration (PIN) had expired and there was no record made in their file to show it had been renewed. Both nurses said their PINs were up to date.

The above amounts to a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were concerned that the registered manager and the provider were not sending all the required notifications to us. There was no procedure in the home for reporting incidents to us, to help senior staff know what needed to be reported. They had not notified us of Deprivation of Liberty authorisations or of the hoists being out of action and disrupting the care provided. We were made aware of this by a professional who visited the home.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 which requires providers to report certain events.

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons did not notify us of some incidents that require notification.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments did not always clearly indicate if a person could give consent. One person had a care plan that there was no evidence they had consented to. 11(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate supervision, appraisal and support. 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons were not ensuring appropriate care to meet people's needs and reflect their preferences, by; (b) designing care with a view to achieving service users' preferences, (d) enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible, .

The enforcement action we took:

warning notce

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons were not providing all care and treatment in a safe way by: (1)(2) (a)(b) assessing the risks to the health and safety of service users receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks (e) ensuring that the equipment used for providing care or treatment to service users was safe for such use and used in a safe way (g) ensuring the proper and safe management of medicines (h) assessing the risk of, and preventing, detecting and controlling the spread of infections.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 14 HSCA RA Regulations 2014 Meeting

personal care	nutritional and hydration needs The registered persons were not ensuring the nutritional and hydration needs of people were met, by: (1)(4)(b) – ensuring service users received dietary supplements when prescribed by a healthcare professional (c) meeting reasonable requirements of service users arising from their preferences or their religious or cultural background

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons were not operating effective systems and processes to ensure good governance, by; (a) assessing, monitoring and improving the quality and safety of services (b) assessing, monitoring and mitigating risks to the health, safety and welfare of service users and others (c) maintaining service user records securely.

The enforcement action we took:

warning notice