Tameng Care Limited

St Catherine's Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

St Catherine's Care Home Horwich, Bolton is a purpose built two storey care home. The home is close to Horwich town centre and close to a bus route and the motorway network. The home provides nursing care for 30 people and care for 30 people living with dementia in a separate area of the home called Pike View.

This inspection took place on 07 December 2017 and was unannounced. The last inspection took place on 10 January 2017 and the overall rating was good.

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

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

At this inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to medication, infection control, governance, staff training, mitigating risk, person centred care and dignity. You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

Systems were in place to ensure staff were safely recruited. Staff told us they received the training and supervision they needed to be able to carry out their roles effectively. Staff completed an induction on commencing work at the home.

The training record provided by the registered manager highlighted there were gaps in essential training for staff.

People who used the service and their relatives told us they felt safe and their relatives were well cared for.

We found that medicines were not managed safely and people did not always get their medicines in a timely manner.

We found that the home was not clean and systems were not being adhered to reduce the risk of cross infection in the home.

Health and safety checks were in place with regard to equipment and servicing of appliances.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People who used the service told us staff were kind and caring. We observed staff interacted well with people throughout the day. People's privacy was respected. However, people's dignity was not always maintained. For example it was noted that faeces was on bedding and mattresses in people's rooms when beds had been made and not cleaned.

We saw a good range of information in care plans, including care plans for pressure ulcers and wound care. These were not all completed accurately and fully. Care plans had been reviewed as required.

There was a range of activities provided both in the home and trips out to local venues

The service had an up to date complaints procedure for receiving, handling and responding to complaints.

A service user guide was available. This provided information about the home and the care people could expect to receive.

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 safe.

People told us they felt safe living at the home. The home was not clean and infection control was poor.

Staff had been safely recruited Safeguarding .policies and procedures were in place. Staff had received training and were confident to report any concerns.

Medicines were not got given in a safe and timely manner and recorded as required.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw that a detailed assessment was completed before people were accepted to the service.

Staff received the induction, training gaps in training and supervision they required to be able to provide safe and effective care.

The service was working within the legal requirements of the Mental Health Act (2005) MCA) and the Deprivation of Liberty Safeguards (DoLS) .

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who used the service told us staff were kind and caring. We observed staff interacted well with people throughout the day. People's privacy was respected.

People's dignity was not always maintained.

There was a service user guide given to prospective service users and their families.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were encouraged to provide feedback on the service they received. Any complaints or suggestions were acted upon to help improve people's experience of the service.

We looked at the care records for nine people who used the service. We noted these contained detailed information regarding people's health and social care needs. However, we found that for one person there was no care plans and we found that several charts had not been completed.

People's end of life wishes were recorded.

There was a range of activities provided both in the home and trips out to local venues

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

People told us that they felt the manager was approachable and staff felt supported by the manager

Basic quality assurance systems and checks were in place to monitor and assess the quality of the service.

St Catherine's Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by the local authority safeguarding team with regard to serious medication incidents. Bolton Community Infection and Prevention Control team also raised concerns about on-going poor infection control issues.

The inspection took place on 07 December 2017 and was unannounced. The inspection team consisted of three adult social care inspectors and a medicines inspector from the Care Quality Commission and two experts by experience. An expert by experience is a person who has had personal experience of using or caring for someone who used this type of service. Both experts by experience had personal experience with older people and people living with dementia.

Prior to the inspection we looked at information we had received about the service. This included notifications, safeguarding concerns and whistle blowing information. Due to the concerns raised we brought forward the inspection of St Catherine's therefore due to time constraints we did not request a provider information record (PIR). This is a form that asks the provider to give us some key information about what the service does well and what improvements they plan to make.

We also contacted the local authority, the Clinical Commission Group (CCG), the local authority safeguarding team, the Community Infection Prevention and Control team and Healthwatch Bolton. Healthwatch is an independent consumer champion for health and social care. This helped to gain an overview of what people experienced when accessing the service.

During the inspection we spoke with 15 people who used the service,10 relatives, eight members of staff, the cook, the registered manager and the regional manager

We looked at nine care records, six staff personnel files, training records staff supervision records, 19

medication administration records (MARs) and audits and meeting minutes.

Inadequate

Is the service safe?

Our findings

Family members we spoke to at St Catherine's felt their relatives were safe. One family member said their relative was, "In a good home here". Another said they were, "Very satisfied and wouldn't have [their relative] anywhere else". Three family members felt that there wasn't always enough staff on duty. One family member told us they had observed that there were periods when there was no staff member present in the large communal lounge. They mentioned that on one occasion they had to go and find a staff member when two gentlemen where involved in an altercation and upsetting other people. Other family members we spoke to were happy with the attention their relatives received.

We checked to see that staff had been safely recruited. We reviewed six staff personnel files and saw that each file contained an application form with included a full employment history, two references, interview notes and confirmation of the person's identity. Checks had also been carried out with the Disclosure and Barring Service (DBS) for all applicants. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff.

We asked people if they thought there were enough staff on duty. One person told us, "They don't have enough staff especially in the evening, They use a lot of agency staff". A relative told us, "They need more staff at lunchtimes to provide assistance". We observed staff assisting people with their meals in a sensitive way.

The layout of Pike View allows people to walk around freely and with purpose. There were several lounges and the conservatory for people to spend time in. There were sufficient staff on duty to care for people but we found they were not always visible due the layout of the building.

We looked at the staffing rotas and found a discrepancy on the rota. For example for one person the rota showed they were on day off on 04,07 and10 of December 2017 and working 05, 06,08 and 09 of December 2017. We questioned this with the registered manager as they had previously told us this person was on long term sick. The registered manager told us this was a mistake and this person was off on long term sick.

We looked at the systems in place for managing medicines with the home. This included the receipt, storage, recording and disposal of medicines. We also checked the medicine administration records (MARs) for 19 people and observed how four people were offered their medicines.

The drug room where medicines were stored had a keypad lock. Medicines were stored in cabinets and a medication fridge. Temperature monitoring was undertaken, however room temperature records had not been completed for December 2017. Records for 17 November 2017 had gaps in daily recording. The fridge temperature was in range and maximum and minimum temperatures were being recorded from the fridge sensor. The medication fridge was locked. We saw that there was a stool sample which had been taken on the 06 December 2017 in the morning. This was in a non-secured stool container and not stored in a laboratory bag in the medicines fridge. The sample should have been taken to the GP's surgery on the 06

December 2017. Staff spoken with were unsure why it had been taken and why it was still there. Only medicines should be stored in a medicines fridge.

We found that for one person that Oxycodone (narcotic medication to relieve moderate to severe pain) liquid with a 28 days expiry date was identified as opened on 01 October 2017 and needed to be disposed of. For another person Senokot (laxative) liquid had expired in November 2017. This was found in the homely remedies stock. We found that for a third person their Lacrilube (eye ointment) was in the drugs trolley and had been opened on 01October 2017. This should have been discarded after one month. Out of date medicines may not work effectively.

There were examples of creams prescribed on MARs, however creams charts were not being used to show that staff had applied cream as directed and to which part of the body the cream was to be applied. We saw for one person who had dementia that three tubs of the same cream were found in the wardrobe in their bedroom, another of the same cream was left in a box unsecure and a tube of cream not belonging to the person was also found. The bedroom door was unlocked so people could access the creams which could be potentially harmful if ingested .

We found in another bedroom that Ensure (prescribed supplement drink) and a cream was left unsecure. This person self-administered the cream. However no self-administration assessment had been completed. For another person we found inhalers were left on a table in their room. There was no self-administration assessment. In another person's room Procal shots (nutritional supplements) were left unsecured. During the medicines administration round, two inhalers were observed left unattended on top of the trolley whilst the administration round was being undertaken. These could have picked up and used by people.

We observed that one person who required a thickening agent in all drinks (added to assist with swallowing) was given paracetamol tablets which they had to chew to swallow them. This placed the person of risk of choking and paracetamol should not be crushed without seeking advice.

We saw that several people were prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes food, to people who have difficulty swallowing. Thickeners may help prevent people from choking. A discussion with the care staff showed they knew when the thickeners were to be given and how much was required for each person. Records showed however that the care staff were not always recording when they had given the prescribed thickener. To ensure that people are given their medicines consistently and as prescribed, it is essential that care staff record each time when they have given the thickener. They must record how much thickener is added to how much fluid.

Where medicines were being administered covertly, consent from the family and GP was available however there was no documentation to demonstrate authorisation from GP (or advice from pharmacist) as to how to crush medicines or administration details personalised for that person.

Controlled drug (CDs) records were inspected. No anomalies in records were found.CD stock levels were checked and reconciled against the CD register. CD counts matched and there were no omissions noted in the CD register.

There were several crates of waste medicines and two CD Destruction (Doop) kits in the medicines treatment room awaiting collection for destruction.

PRN (as and when required) prescriptions protocols had not been consistently reviewed. For example PRN protocol for Tegretol 100mg (used to treat epilepsy) was prescribed and being administered regularly

according to MARs.

People had access to homely medicines. Homely remedies consent (or non-consent) was not available for all residents and where the form was in the file it had not been reviewed in 6 months as per the homes policy. People's allergy status was not always documented on their MAR records detail page. This meant that people could have an adverse reaction to certain medicines.

We saw a loose oxygen cylinder in one person's bedroom. For safety reasons this should be stored an appropriate oxygen cylinder holder. We discussed this with the registered manager during feedback who agreed to address this issue.

Family members spoken to were generally happy with the management and administration of their relatives' medication. One family member told us their relative tended to wake early, however they might not receive their morning medication until 11am. On the day of our visit we observed that morning medications in Pike View were still being given at 12 noon. We discussed this with the registered manager who told us that it was the nurses first shift at the home. However, finishing the morning medication round so late could impact on when the lunch time medicines could be administered.

A Medicines Policy was available as a hard copy and on the home's intranet, however there was no self-medication policy available. Audit documents and templates within the appendices of the medicines policy were not being used.

We found this was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – medicines were not managed safely

Prior to our inspection we were made aware by Bolton Community Infection Prevention and Control Team that they had serious concerns about infection control procedures at the home. The team had visited on a regular basis and provided support and training. On 07 December 2017 a specialist infection control nurse was at the home. The specialist nurse found: dried faecal matter throughout Pike View, this was on light switches, door handles, toilet frames, walls, mattresses, linen and bed frames. The kitchen and fridge in Pike View was dirty. The sluices were dirty and it was observed that staff were not cleaning commode pans with any cleaning fluid. There was inconsistent management of the disposal of incontinence products. Staff were not using the clear plastic bags as required and were walking around Pike View with unbagged incontinence items. There were no cleaning materials available for staff to clean after each person had received personal care in bathrooms and bedrooms. Wheelchairs were dirty and required cleaning. Throughout the home several of the soap dispensers were found to be empty and on one dispenser the plastic covering was broken with jagged, sharp edges which could cause a serious injury. In certain areas of the home there some malodours. Cleaning records were not available and cleaners were not fulfilling full cleaning duties when observed. There was a lack of infection control leadership and management within the home. One member of staff told us, "It's confusing who cleans what. We have no clear view of who is responsible". The inspector accompanied the specialist nurse around Pike View and observed the lack of infection control procedures.

We looked at the training record and found that one care assistant had not updated infection training since November 2011. Sixteen care assistant had not updated training since 2015. The registered manager and a registered mental health nurse had not received training since 2015. Three registered general nurses and five care assistants had not had infection control training.

We found this was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Infection Control

We observed that in one of the bathrooms in Pike View in the bathroom cupboard there were communal toiletries. This included shampoo, ladies and gent's shaving cream and three wet shave razors. This could be potentially dangerous to people who are living with dementia as they may ingest the liquids and lack awareness of the danger of unguarded razor blades. People living at the home should have their own toiletries, which for some people should be securely locked away in their bedrooms.

We also found in Pike View that the bath check temperature file in the bathroom which had an assisted bath and was regularly used that the charts had not been completed and signed by staff. We also found the water temperature was well below the recommended water temperature for bathing for older people of 43 degrees. Temperatures were reading as 32.4 degrees on 27 March 2017 to 39.1degress on 06 June 2017. No records were of the correct temperature. For people in Pike View, of who have advanced dementia most would not be able to express to staff that the water was cold. This meant that people would not be able to experience a warm and pleasant bathing time.

We found that most of toilet seats in Pike View were ill fitted and loose this could be both uncomfortable and unsteady for people.

We looked around the home. The bedrooms, dining room, lounge and corridors were well lit and bright. The provider had taken steps to ensure the safety of people who used the service by ensuring the windows were fitted with restrictors On the first floor we found this part of the home to be cold. We found that one person who was nursed in bed had cotton nightie and a short sleeved cardigan. It was late afternoon and the temperature outside was very cold. This person's bed was underneath the window which was open and the duvet was thin. This person was cold to touch. This was discussed with the registered manager and the regional manager who agreed to keep a check on the temperatures around the home.

In one person's room we saw a small oiled filled free standing heater. This was discussed with the registered manager about the safety aspect. The registered manager agreed to remove the heater. Unguarded radiators pose a serious risk of harm to people who use the service.

We saw that regular services were carried out on moving and handling equipment such as hoists and bath lifts ,the passenger lift had a thorough examination lift certificate dated 23 November 2017. We saw that the water supply had been tested to help prevent legionella and the gas and electrical supplies had been tested and certificates were valid. Fire equipment ,had been tested and serviced. Each person had a personal emergency evacuation plan (PEEPs) These were kept in the foyer of the home. A PEEPs informs the fire service of where each person's room is and what assistance they need to evacuate them in the event of fire.

We saw that accident and incidents were recorded and the registered manager notified the CQC as required.

Requires Improvement

Is the service effective?

Our findings

We saw that all new staff completed an induction on starting work at the home. Staff told us they thought the induction was thorough and there was support from being buddied with an experienced member of staff. There was a probationary period that could be extended if required and competency checks were undertaken to ensure that new staff were confident to take on their role.

A senior member of staff spoken with said, "There's lots of training and I feel it is appropriate. Some training is only for the seniors and the carers would benefit from it. For example pressure ulcers, then they would understand the importance of turning and documentation. Similarly carers should be more involved in safeguarding so they would understand the importance. I have put these suggestions forward".

We looked at the staff training record which listed 77 staff names. We saw some staff had not completed training. For example six care assistants, two senior carers, one care home assistant practitioner (CHAP) and four nurses had completed person centred care and for one person this was as far back as 2009. Most staff had completed training in moving and handling, but for one person this had not been updated since 2015. Most staff had completed infection control training. For some people this needed to be updated. Five staff had completed basic first aid training for three of these staff this was completed in 2014. Two staff had completed resident experience training in 2013. Seventeen staff including nine care assistant, two domestics, one CHAP, one senior carer, three nurses and the registered manager had up to date training in caring for people with swallowing difficulties. Fourteen care assistants had completed training in oral hygiene, none of the registered nurses had completed this training. Three staff had completed training in pureed and fortified diets. Nineteen staff had completed training in catheter care, these included 10 care assistants, two domestics, three senior carers, three qualified nurses and the registered manager. The lack of training meant that some staff had not been equipped to carry out their role effectively and safely.

We found this was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing

We asked staff about one to one staff supervisions. One to one meetings provided staff with the opportunity to discuss with the management any worries or concerns they may have and any development and training they may wish to undertake. One member of staff told us, "There are lots of team meetings and supervisions are two monthly. However the training record emailed following the inspection showed that only two staff had received supervisions since 2015.

We spoke with one person who used the service to ask if they felt they were involved in the decision making about their care and treatment. They told us they were able to make their own decisions about their daily routines such as; when they went to bed, when they got up in the morning, if and when they wanted to have a 'lie down' and where they chose to spend their day. They told us, "It's thanks to the staff here that I am now so much better than when I came in. The staff always ask me first before they do anything. They are lovely".

In the care files we looked at there was consent for photographs to be taken and a care plan had been agreed and signed by the person or their representative where appropriate.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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 saw that DoLS information was documented and was accurate. Staff spoken with had a good understanding of MCA and DoLS. We saw that information regarding people's capacity had been assessed and information was in the care files. These were evaluated monthly. The registered manager notified the CQC as required of DoLS authorisations.

We observed the lunchtime meal and one of the experts by experience joined people for lunch. The expert by experience described the food as alright but the soup was cold. The registered manager agreed to look into this matter.

We spoke to the chef who told us food was cooked fresh on-site each day. The catering contract is out-sourced and the suppliers and the menus were largely determined by the contracting company. When first out-sourced, the chef felt the menu was more restricted than previously. The registered manager and chef have since had discussions with the contracting company and are now able to use a certain amount of discretion, replacing menu items they feel are not to people's liking. One person told us, "The food is not as good as it used to be". One family member said, "The chef is great". A family member said "[Their relative] ate everything they were given". Another person told us, " When I first came here the food was good, in the last three months it's not so nice. Some days it's better than others. For example you get a quiche but nothing with it. The rice pudding the other day they had to chisel out the pan".

A cooked breakfast was available for those that wanted it; a choice of soup and sandwiches or a light meal was offered at lunch time; the main meal was served at teatime. The kitchen catered for diabetics and those requiring soft diets or pureed food and liaised with the nursing staff and the Speech and Language therapy team (SALT) as required. A board in the kitchen was used to track all people's dietary requirements. There was also a book in the kitchen, maintained by the care staff, of the residents likes and dislikes. We saw for one person who was on a pureed diet and thickened drinks the food chart indicated that they had been given sandwiches for their supper. This placed this person at risk of choking. We discussed this with the registered manager who confirmed to look into this to check if this was a recording issue or if the person had received the wrong consistency of food.

We observed in Pike View a number of residents ate their lunch in the dining room served by three carers, one of whom was assisting a person who required full support to eat their meal. The carer was friendly and patient, chatting to the person and the others at the table. People were offered a choice of tea or coffee with their meal.

Two people were assisted by their relatives with their meal as was their choice. They wished to be actively

involved with caring for their relatives.

The carers in the dining room wore disposable aprons. However there did not appear to be any wet wipes readily available to clean anyone's hands. This contradicted one of the audit checks showed that wet wipes were always available for people to wipe their hands before and after their meals. A carer had to go out of the room to get some paper towel for a person who needed to wipe their hands.

Some people, who required support, were given their meals in the lounges. This was also the case at breakfast, which was served to people when they wish to dine.

There was also a small kitchen near the lounge which was used by staff and family members to make drinks for residents.

We asked the manager about how information was passed to the hospital should a person need to be admitted. The home is part of the 'Red Bag' Initiative was rolled out to all nursing homes across Bolton NHS Foundation Trust on 13 November 2017. It aims to improve the experience of people when they are admitted to hospital, and reduce their length of stay by speeding up the discharge process and improving communication between hospitals and nursing homes. The distinctive red bags can be easily packed in a hurry and should contain important care notes belonging to the person, all their medication, and personal items such as a pair of slippers, a change of clothes for when they are returning home and things like their spectacles, dentures and a reading book for passing the time. The bag will be handed over to ambulance staff and then passed on to hospital staff on admittance. The bag will identify the person as living at a care home and should be updated with all the relevant paperwork to ensure a speedy discharge when the time comes.

We looked at the design of the premises. Pike View had a large open plan lounge and seating areas on two sides of the main walkway. People were able to walk around the home with purpose. Seating was arranged in small groups so people could enjoy one another's company. There was also a smaller lounge which, during our visit, was being used by four people in the recliner wheelchairs who were listening to music. Both lounges were decorated for Christmas.

There was a small courtyard accessible from the main lounge and a larger garden accessible from the conservatory. Both areas are enclosed and are provided with seating areas.

Consideration had been given to signage in Pike View. Bedroom doors were labelled with the room number, people's name and photograph. Bathrooms and toilets also had appropriate signage. Corridors and lounges were hung with pictures, including some 1930s-50s advertisements and family scenes.

The building was fitted with a buzzer system which we heard activated on occasions during the day. A number of people would not be able to use such a system so relied on staff checking on them. This was observed throughout the day.

We noted that while the temperature in the main lounge, was perfectly comfortable for staff and visitors, it did not feel as warm as would normally be expected for this environment. We observed several people had been given extra blankets.

Upstairs we observed that Christmas decorations were up in the lounges and corridors. There were a number of communal lounges and dining areas. The carpet on the main corridor required attention as this was heavily stained. The rooms and corridors were wide enough to move equipment around as required.

Where possible people from upstairs came down to sit in the conservatory. This area was found to be warm and comfortable.

Requires Improvement

Is the service caring?

Our findings

We spoke with family members of people in Pike View. They felt the staff were good, proficient at getting to know the residents and welcoming to their families. One family member said, "The staff, are very good", and another said, "The staff are brilliant".

We observed the staff to be kind and compassionate, while remaining bright and cheerful. We saw a care worker chatting with one person and arranging the seating to make it easier for the second person to join the conversation. Each person was greeted by the carers as they came into the lounge and those people who had difficulty communicating looked pleased and relaxed when the carers spoke to them or approached them.

People's privacy was respected. However, people's dignity was not always maintained. For example it was noted that faeces was on bedding and mattresses in people's rooms when beds had been made and not cleaned.
We found this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity.

There were no restrictions on visiting the home. One family member told us "Come when you want and stay as long as you like".

In other areas of the home one person said, " I'm happy with the care. They [staff] have helped me, they treat me like a proper person. They are kind and compassionate and treat you with respect, and they listen to you". Another person said, "They [staff] are very kind and look after each patient as an individual, considering they are on minimum wages. You can have a laugh with them".

We spoke with relatives, one said, "Yes, they are kind and compassionate and I have a good rapport with them, they seem to be a mixed age group. They definitely treat people with respect." Another relative said, "They make time for them, they don't treat them like babies, they are treated with respect. If there are any concerns they get the nurse".

Staff spoken with told us , "I love the job; it's changed a lot and is a lot more clinical. There are more nursing needs, people are not as mobile as they were". Another said, "A few [people who use the service] like to chat and I try to do that". A third staff member said, "I like the feeling when you've made a difference to someone's life, especially if they have no family".

Care plans we looked at showed people were involved with care planning and reviews. Relatives, where appropriate were also included in reviews and updates about their relatives' wellbeing.

We asked about equality and diversity and were told that any person from an ethnic minority group would have their needs met by their choice of diet and their spiritual and cultural needs attend to.

There was a service user guide available to people who were looking for a care home. This provided information on the staffing structure, the facilities available, fees and what care and support people could receive.

Requires Improvement

Is the service responsive?

Our findings

We looked at nine care records. The care records we looked at contained sufficient information to show how people were to be supported and cared for. We saw that assessments were undertaken prior to the person being admitted to the home; this was to ensure their identified needs could be met. The care records were reviewed at least monthly to ensure the information was accurate and relevant.

The care records also contained risk assessments. These were in relation to assessing risks if people had problems with certain aspects of their health, such as a history of falls, a need for support with moving and handling or being at risk of developing pressure ulcers. Staff had written down what action they would need to take to reduce or eliminate any identified risk. For example use of any specialist equipment such as hoists and slings, bed sensors and suitable mattresses.

One of the care records that we looked at was for a person who was receiving end of life care. We saw there was a Do Not Attempt Resuscitation (DNAR) in place that was easily accessible and visible in the person's care record. This is a legal document that identifies that an informed decision has been taken to withhold cardiopulmonary resuscitation (CPR).

The care record contained information to guide staff and show how the person was to be supported and cared for. It was clear from the information contained within the care record that family members had been in discussion with staff around the end of life care needs and wishes of the person who used the service.

It was identified in the care record that the person was at risk of developing pressure ulcers. A pressure ulcer prevention care plan had been put into place to help reduce or eliminate the risk. This prevention care plan contained information such as; the care of incontinence, moving and handling, nutrition, plus the pressure relieving equipment that was needed. There was no information however in relation to how often the person needed to have their position changed; necessary to help further reduce pressure. The registered nurse informed us that this was an oversight in the documentation as the staff regularly changed the person's position. We were told that positional changes were to be undertaken at least every four hours.

We looked at the 'positional change' chart in place for this person. The chart showed that positional changes were undertaken usually every four hours. We saw however that on two separate occasions it was documented that the person had not had their position changed for seven hours and eight hours respectively. The registered nurse told us she felt sure the person would have been repositioned and that it was very probable that staff had failed to document what they had done.

For another person we saw there was a good care plan in place for a small wound this person had sustained on their hand. The wound care plan detailed the size, condition and treatment for the wound. It was documented that the wound was last dressed on 24 November 2017. There was no further documentation. We asked the registered nurse about the progress of the wound and we were informed that the wound had healed. The should have been documented.

It was recorded in the care record of a person being cared for on the nursing unit, that they had a wound that needed regular treatment and dressing. The wound care plan in place was detailed. It was documented that the wound was last dressed on 22 November 2017 and was to be checked again within four to five days. There was no further documentation. We asked the registered nurse about the progress of the wound and we were informed that the wound had healed.

We stressed the importance of ensuring that care documentation is kept up to date so that it accurately reflects a person's current support needs.

We looked at the care record for a person who had been admitted to the nursing unit of the home ten days prior to the inspection. Information in the care record showed that this person had several medical conditions; two of which could result in a sudden medical emergency arising. Although there was information about the medication the person was taking to help control the conditions, there were no care plans in place to guide staff in the care and treatment required in an emergency. To reduce the risk of people receiving unsafe or inappropriate care, a care plan showing how to deal with each medical emergency must be in place. There were also no care plans in place for the following aspects of this person's care; personal hygiene, continence, nutrition and skin integrity.

We found this was a breach of Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Person centred care The provider had failed to have a care plan in place to show how a person's needs and preferences are to be met.

We saw that assessments had been undertaken for risks to the person's health such as; a history of falls, pressure ulcers, nutrition and choking. Although it was identified that the person was at risk of falling, no care plan had been implemented to reduce or eliminate this risk.

We found this was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment The provider had failed to do all that is reasonably practicable to mitigate this risk.

We looked at five care monitoring charts. Depending on the persons' individual needs, the charts monitored such activities as positional changes, food and fluid intake, teeth and denture cleaning and sleep activity. We found omissions of documentation in all five charts.

On one chart there was no recording of the person having had their teeth cleaned since 26 November 2017, a period of 11 days. The other chart showed the person had not had their teeth cleaned since 5 December 2017, a period of two days. This was discussed with the registered manager for them to check that people received the correct oral hygiene.

The food and fluid intake charts of two people showed they had received no food or fluid on the day of the inspection, 07 December 2017. We also saw that for another person the food and fluid chart had not been fully completed . For example on 04 December 2017 lunch was record at 13:00 and a drink at 15:40 there was no record of this person having been offered an evening meal or a supper .The next recording on the chart was at 09.00 on 05 December 2017. This showed a gap of 20 hours in between meals. We discussed this with the registered manager who assured us that no one would have gone without appropriate nutrition. The registered manager confirmed they would look into this matter to ensure all this person food and fluid intake would be recorded.

The sleep activity chart of one person showed there was no recording from the 21 November 2017 until 27

November 2017 and then no recording of their sleep activity from 01.00 hours on 5 December 2017 to 7 December 2017. For another person the sleep activity charts showed staff had failed to sign the charts to show they had checked on people. From the 01 December –05 December 2017 staff signatures were missing. On 06 December 2017 eight signatures were missing. We discussed this with the registered manager as to what value the sleep activity charts provided. This could not be clearly explained, however the registered manager agreed to look if the sleep activity charts were required for all people and who would benefit from having a chart.

We saw for one person that the mattress setting charts had not been checked on a daily basis to ensure the setting was correct. Dates were missing from 07October 2017 to 20 November 2017 when no other checks had been made. This meant we and the staff could not check if the bed was working properly and providing the correct support for this person. This was discussed with the registered manager who confirmed that action would be taken to ensure that the mattresses were checked and information recorded.

We found this was a breach of Regulation 17 (2) (c)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Governance The provider had failed to have an accurate, complete record of the care and treatment provided to people who use the service

We asked one of the registered nurses and the registered manager to tell us how staff cared for people who were very ill and at the end of their life. We were told that the registered nurses were very experienced in caring for people nearing the end of their life. We were also told that some staff had received varying degrees of sessional end of life training mainly at the local hospice.

From the training record provided by the registered manager we saw that two staff had completed training in system control for end of life care and four staff had completed a dementia and end of life study day.

During the inspection we noted there was a poster in the reception area displaying information about the Gold Standard Framework (GSF). GSF is a systematic, evidence based approach to providing the best possible care for all people approaching the end of life. To qualify for accreditation for the GSF, care homes must have undertaken the full GSFCH training programme over 9 months, embedded this into their homes for at least 6 months and then undertaken a rigorous accreditation process 'Going for Gold'.

We asked the registered manager if they had received the GSF accreditation. We were told that none of the staff had completed the training and no further training had been undertaken. The registered manager told us they would remove the displayed information from the reception area as it was not valid and could be seen as misleading.

We looked at the system for managing complaints in the service. We noted a complaints procedure was in place which provided information about the process for responding to and investigating complaints. Information was also on display in the communal areas to advise people how they could provide feedback on the service they received. People we spoke with during the inspection told us they knew how to make a complaint if they were dissatisfied with the support they received and were confident their concerns would be taken seriously.

We saw a number of compliments cards that had been sent to the home by family and friends. Comments included: "Thank you for all your hard work" and "Thank you for the big birthday and all the support given".

We saw that the home provided people with a range of activities. Each person had book which these were documented in. The home was ready for the Christmas festivities and on arrival at the home we saw

Christmas gifts and cakes that were to be raffled off. The home was expecting a visit from children from a nearby nursery and from a choir at a local church. People had also been to a Christmas pantomime. Other activities included knit and natter, quizzes, baking, art and crafts and trips out to local venues in the mini bus on Thursdays. The local church attended the home on a regular basis to offer communion. In Pike View in the main lounge there rummage boxes. We saw two people with dolls or cuddly toys. There was a television on in one part of the main lounge and music playing in both lounges.

Requires Improvement

Is the service well-led?

Our findings

The service had a manager in place who was registered with the Care Quality Commission (CQC) and was qualified to undertake the role. The registered manager had worked at the service for several years. The registered manager was supported by a deputy manager and the regional manager.

People we spoke with all knew the manager and told us she was approachable and supportive. We spoke with staff who said, "The manager is very supportive". Another said, "They [management] are absolutely brilliant and I can't thank them enough for their support".

Before our inspection we checked the records we held about the service. We found that the registered manager had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe.

We saw that a log was maintained of any accidents and incidents which had occurred; this was reviewed regularly to see what lessons could be learned to help improve the service people received.

Records we reviewed showed regular staff and residents' meetings took place. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice.

We looked at the arrangements in place for quality assurance and governance. Quality and governance processes are systems that help registered providers to assess the safety and quality of their services. This should ensure they provided people with a good service and meet appropriate quality standards and legal obligations.

We saw there was a system of audits checks in place. These related to the environment, medication, equipment, food and health and safety, person's experiences and end of life care and recording.

There had been an infection control audit on 15 November 2017. The audits were tick boxes exercises and had clearly not identified the infection control issues we found during our inspection and at previous infection control audits by the specialist nurse. The registered manager had failed to check that the infection control audits were correct and that standards were maintained.

There was no evidence of audit and oversight of the medicines management processes. Audit checklists were being completed for medicines but there was no evidence of follow-up. The audits needed to be more robust, completed accurately and provide an overview and analysis of themes and patterns and lessons learned.

The registered manager had failed to check that records were being completed accurately with regard to food and fluid charts, sleep activity charts, and positional charts.

We asked the registered manager about key achievements. Several of the staff had completed a dementia training programme and staff, people who used the service and relatives were invited to a buffet to celebrate their achievement.

This service cannot be judged as good in the well-led domain because we have identified breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2014. Where a breach has been identified in a domain the well-led section cannot be rated as good.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to have a care plan in place to show how a person's needs and preferences are to be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people's dignity was maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed safely. The provider had failed to ensure that infection prevention and control measures where in place. The provider had failed to do all that is reasonably practicable to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have an accurate, complete record of care and treatment provided to people who used the service.

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 The provider had failed to ensure that staff had received relevant and up to date training.