Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 9 August 2016 and 5 September 2016 and was unannounced. Haven Nursing Home is a large nursing home which provides nursing care for up to 70 people, across three units. People who need more staff input are mainly supported in Birch Unit. Older people and people with more complex nursing needs are mainly supported in Oak and Elm units. At the time of our visit there were 49 people living in the home.

At our last inspection in March 2016, there were three breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

These breaches were in relation to the support people received. Care was 'task focused', not focused on the needs of each person. Staff did not have the time to support people with interests or activities. People in the Birch unit experienced very little engagement to meet their social care needs. The provider did not ensure the proper and safe use of medicines. Risks were not always recorded and responded to appropriately; there was not an effective and accessible system for complaints; the provider did not have effective systems and processes to make sure they assessed and monitored their service.

Following the September inspection, we issued the provider with a Warning Notice in relation to the lack of effective oversight and the home was put into 'special measures'. When we inspected in March 2016 we found the requirements of the warning notice had not been met and the home remained in special measures.

The provider sent us an action plan which detailed the actions they were taking to improve the service. At this inspection we found that there was enough improvement to take the provider out of special measures however further improvements were still required.

A new manager was appointed in May 2016. The manager has submitted an application to us so they can be 'registered'. 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.

Since the March inspection, there had been some improvement in the management of medicines, and the provider had taken steps to ensure people received their medicines safely and as prescribed. However, guidelines which were now in place for staff to administer medicines to people on as 'as required' basis, continued to require improvement.

The provider now ensured they received, handled and learnt from complaints and concerns raised by people.

People continued to be supported in ways that were task focussed and were not person centred. Care plans did not support staff to provide personalised care consistently as they had not always been reviewed and information in them was not always accurate. This meant assessments intended to identify and address risks to people's health and safety had not always been updated.

There were enough staff were on duty to meet people's needs. However, people sometimes had to wait longer than they should for needs to be met, and staff said they sometimes struggled to meet people's needs. The provider used agency staff, but recruitment for permanent staff was underway.

Staff were clear about their responsibilities under the MCA (Mental Capacity Act 2005) and DoLS (Deprivation of Liberty Safeguards) legislation. The manager understood their responsibilities and had ensured applications had been made to the appropriate body. However, these had not always been followed up with the local authority where delays in assessing restrictions were experienced.

People living with dementia were properly supported. People's needs had been reassessed and those living with dementia had now begun to be integrated into the rest of the home, and the unit where people living with dementia had been supported no longer had a locked door. This gave people more freedom and provided them with more and varied interactions.

Staff were respectful and treated people with dignity and respect. We observed this in interactions between people, and records confirmed how people's privacy and dignity was maintained.

More effective systems were now in place to check the quality and safety of service provided, although these had not picked up on some of the issues we identified. There was now better governance, so the service people received could improve.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were being managed safely and there were systems in place to monitor and check this. People received their medicines safely and as prescribed.
Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures in place to ensure they recruited people who were suitable to work in the home.
There were not always enough staff available at the right times to ensure people received the support they needed, but the manager was aware of this and was looking at ways to manage this more effectively.
Risks were not always properly assessed and managed, as some people's care plans had not been reviewed and updated with current and accurate information.
Where people were at risk of dehydration or malnutrition, this had been assessed, but records intended to help monitor and address this were not always accurate.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity to understand and make decisions had been assessed as required. Applications had been made to assess restrictions in place to keep people safe, but these had not always been followed up where delays occurred.
People had access to health professionals where required, and referrals were made for specialist intervention where required.
Training had taken place, and more was planned in order to ensure staff had the knowledge required to support people safely, however new staff had not always been provided with the support they required.
Where people were at risk of dehydration or malnutrition, this had been assessed, but records intended to help monitor and address this were not always accurate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us staff treated them with dignity and respect.
People had their privacy maintained and staff asked people's permission before supporting them.
People were offered choices and were supported by staff to be independent.
Staff did not always have time to interact with people to enhance their well-being, and care records were not always written in a personalised way.

Is the service responsive?

Requires Improvement

People throughout the home were given opportunities to follow their interests or be involved in social activities. Complaints were responded to in a timely way, and it was clear for people and their relatives what they could expect from the manager if they raised a complaint or concern. Care was not always responsive to people's individual needs, and staff could not always respond to risks to people's health, safety and well being. This was because care plans were not always up to date or accurate.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A new manager was appointed following our inspection in March 2016. They had identified areas for improvement and had plans in place to achieve this.
People, staff and relatives told us the manager was responsive and approachable, and was making improvements.
More effective systems were now in place to check the quality of the service being provided and to improve it as a result. However, they had not identified some issues which we found during our visit.
Care was inconsistent when the manager was not in the home, which meant people were at risk of receiving a poorer service at these times.

Haven Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 9 August 2016 and was unannounced. We returned for a second visit on 5 September 2016 so we could check information we had received. The inspection was conducted by two inspectors, an expert by experience, (an expert by experience is person who has personal experience of using or caring for someone who uses this type of care service), and a Nursing Specialist Advisor on the first day, and by one inspector on the second day.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law. We also considered information we received whilst the service had been placed in special measures following the September 2015 inspection.

During our inspection visits, we spoke with 14 people who lived in the home. We also spent time observing interactions between people and staff. We spoke with seven relatives, and one health professional. We also spoke with the manager, the provider/owner and seven staff.

We reviewed 12 people's care records, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2016, we found the provider did not ensure the proper and safe use of medicines. This was a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

During our inspection in August 2016, we found there had been some improvement, and that some action had been taken to ensure people received their medicines safely.

When we inspected in March 2016, we found guidance for the administration of 'as required' medicines known as 'PRN' was not always available. This guidance provides information as to when it is appropriate to administer PRN and ensures people receive their medicines in a consistent manner. During this inspection, the manager told us the pharmacist used by the home had helped to draw up PRN protocols. However, we found that whilst it was now clear what medicines people were being given as PRN, what they had been prescribed for, and when they had been given, there was not detailed information for staff on when they might be needed. Records also showed that PRN medicines were being given on a regular basis, and staff had not always recorded the reason they had been given. There was limited information to inform staff of measures they could take before people were calmed by prescribed medicines. This meant there was a continued risk medicines may be administered before all other interventions had been explored.

We discussed this with the manager, who agreed there was insufficient information for staff on when a particular person might need PRN medicines, especially if they were unable to tell staff. They assured us they would draw up more personal protocols for people, including the reason PRN medicines had been given.

When we inspected the service in March 2016, we found some people received their medicines in a covert manner. This is medicine, hidden, usually in food. Covert administration of medicines may take place when a person regularly refuses their medicine, but they lack the capacity to understand why they need to take the medicine. We found some medicines were being crushed without information or guidance from a pharmacist. This could change how it affected the person. During this inspection, we found there was general information available for staff on covert medicines and how they should be taken. However, one person was being given medicines covertly and it was not clear from their records, or from discussions with a nurse on duty, how this had been agreed and why. We raised this with a member of nursing staff who agreed records were not clear and took immediate action to ensure this was updated. We found that where people were taking covert medicines, records of their administration were kept to ensure they were being given as prescribed.

When we inspected the service in March 2016, we found nursing staff had not received training in the administration of medicines in the past 12 months, nor had they had any competency checks carried out to ensure they remained safe to do this. During this inspection we found some action had been taken to address this. Some of the nursing staff had received medicines training and had been assessed as competent. However, three of the six nursing staff we spoke with had not been 'signed off' as competent. We spoke with the manager about this who took action to ensure all nursing staff were assessed, and updated

their records to ensure they monitored this regularly.

Medicines were stored safely and securely, in locked trolleys in the locked treatment room. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely. Controlled drugs were checked daily to ensure their proper use. When we inspected the service in March 2016 we found medicines requiring cold storage were kept within a refrigerator, and that the temperature was not being monitored effectively. During this inspection we found fridge temperatures were checked daily which reduced the risk of medicines not working properly.

When we inspected the service in March 2016, we found there were no documented audits of the clinic room. During this inspection we found action had been taken to address this and, following discussions with the manager, daily MAR audits were to be commenced, in addition to the weekly medication audits that were already in place.

People we spoke with told us they received their medicines when they needed them. Administration of medicines was recorded clearly on MAR sheets, handwritten additions or changes to them had been checked and signed by a second member of staff. There were no omissions in the administration records. Medicines in stock matched the administration records recorded by the home and stock balances were accurate. The provider maintained accurate and up to date records for the receipt and disposal of medicines.

People we spoke with had mixed views on whether or not they felt safe. One person said, "99% of the time I feel safe." Another person commented, "There are sometimes problems with my buzzer. They sometimes hang it up after making the beds so I cannot reach it. It makes me feel unsafe." During our inspection visit, we saw people's buzzers were within their reach.

Staff told us they thought people were safe, but that improvements were still needed. One staff member said, "People here are safe, but if certain changes were made it would be a lot safer. Risk assessments for example."

Risks relating to people's care needs had not always been identified and assessed. Where they had, these assessments were not always up to date as many had not been recently reviewed. Staff we spoke with were able to tell us how to manage people's risks, and, although the provider used agency staff to ensure there were sufficient staff on duty, the manager had taken steps to ensure they only used agency staff who were familiar with people's needs and were consistent. This reduced the risk to people, but the manager agreed they needed to ensure risk assessments were reviewed and up to date. This work was underway at the time of our inspection visit, and, of the three care plans we reviewed for people who had moved to the home recently, two contained up to date and accurate risk assessments. Immediately following our inspection visit, the manager took action to ensure all care plans and risk assessments were reviewed with people and their families as soon as possible. This helped to ensure people were safe.

Other risks, such as those linked to the premises, or activities that took place at the service, were also risk assessed and agreed actions to minimise those risks. This helped to ensure people were safe in their environment. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. Some of these checks were out of date and it was difficult to tell from the records when they were next due to be completed. However, the manager told us a maintenance co-ordinator had recently been appointed as they had identified some maintenance issues needing attention when they started managing the home. Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. Care records showed people had personal fire

evacuation plans in place which took account of their needs and guided staff on how best to support people in the event of a fire.

Views were mixed on whether or not there were enough staff to meet people's needs. Whilst staffing at the home had increased since our inspection in March 2016, so had the number of people living at the home. Some relatives we spoke with expressed some concerns about the level of staff. One relative said, "It's a real worry at meal times. [Person] needs assistance and encouragement to eat, but there are simply not enough staff." Another relative described how when visiting the home they felt the need to assist a person who they were worried may fall, because staff were not available to offer support. They said, "It's not my job but you can't just leave them [People]." Other relatives we spoke with felt staffing had improved. One relative told us, "No complaints [with staffing] since March 2016 it's been better here. The only one complaint is not having enough backup senior carers. I thought they were going to recruit more?" Another relative commented, "Staff support is very good. My mother gets turned every two hours."

Staff we spoke with told us there were not always enough staff to enable to them to support people. One staff member said, "It can be a worry if you are in the lounge on your own and several people need help." Other staff told us there were enough staff, but only when the provider used agency workers. One staff member said, "If there are the right amount of staff it is fine. We do have agency staff, but it is agency staff we have regularly which is good for the residents."

The provider used agency staff in order to ensure sufficient staff were on duty to meet people's needs. When we inspected in March 2016, we found staff had to give clear direction to agency workers who did not always understand what was expected of them, or of people's needs, where they were at potential risk and how they should be met. However, during this inspection, the manager and staff told us they used consistent and competent agency care and nursing staff to ensure people were well supported. Again, there were mixed views on how effective agency staff were. One relative told us, "Agency staff don't know [Person] so don't understand if what they see is normal for them [Person]. So they just ignore everything and don't report changes." However, other relatives we spoke with said there was now a consistent group of agency staff working in the home who had had a good understanding of people's needs.

We observed a number of examples where staff were unable to support people quickly, because they were either unavailable to support their colleagues to enable a need to be met, or to meet a person's needs themselves. For example, one person was observed to wait for over thirty minutes for a hot chocolate having asked for one. We reminded staff the person was still waiting, and were told they could not make the person a hot chocolate until another staff member returned to the lounge. Another person asked staff if they could use the toilet at 10:55 a.m. The member of staff told the person they would have to buzz for staff to support as they could not leave the lounge area unattended. The person was not assisted to the toilet until 11:20 a.m.

On another occasion, we observed one member of care staff on Birch unit attempting to assist someone to walk, as the person had been assessed as being unsafe to walk unaided. The person was becoming both physically and verbally aggressive and, as the staff member had no means of getting further support, we had to find staff in another lounge to assist. During the time the staff member was trying to support the person so they did not fall, another person was taking left over food from a trolley which was left on the unit. The staff member explained that there were two more members of staff working on Birch unit, but they were both busy supporting someone with their personal care.

We spoke with the manager about staffing, and they told us they thought there were enough staff to support

the people currently living at the home, and that staff numbers would be increased should the number of people at the home increase. However, they acknowledged that staff could potentially be deployed around the home more effectively, and they assured us they would look into this. We also discussed the incident where a staff member had been unable to summon help when trying to assist someone to walk safely. The registered manager assured us the person who had been left unsupervised to pick leftover food from a trolley was not at risk, as they had no specific dietary requirements, though they acknowledged the potential risk. The manager told us they were looking at having a portable buzzer which staff could have with them if left in a communal area alone, so they could summon help quickly and easily.

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to try and ensure new staff were of 'good character.' A recently recruited member of staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

We observed staff did not always move people safely. This placed people and staff members at risk of harm. For example, two care workers were assisting a person to move from a wheelchair to a lounge chair. One care worker placed their hand under the person's armpit, leant backwards and pulled the person to a standing position. We asked the staff member if this was the correct way to assist the person to move safely. The staff said, "Umm, no you do it like this." They then demonstrated the correct technique and confirmed they had recently completed moving people safely training. We shared our observations with the manager. Shortly after our inspection, the manager assured us they had spoken with the staff members concerned to reinforce correct techniques for moving people safely, and had arranged for them to be trained again. The manager also explained the external auditor who completed quality checks on behalf of the provider would be observing practice as part of their audits. They assured us observation of how people are helped to move around the home would be included in these checks.

Most staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. They understood how to look for signs that might be cause for concern. One staff member told us, "If I was concerned, I would report it to the senior and [manager] straight away. I would ring safeguarding myself if it was not dealt with." There was more training planned for those who had not already attended, and we saw plans were in place to offer a variety of times and days so all staff could attend.

Staff told us there were policies and procedures for staff to follow should they be concerned that abuse had happened. The manager had made safeguarding referrals to the local authority, and had worked effectively with other agencies to ensure people were protected. Records were kept to ensure any safeguarding concerns were monitored and lessons could be learnt from them.

Requires Improvement

Is the service effective?

Our findings

People told us staff asked their permission before supporting them. One person commented, "Absolutely. They do explain [what they are doing]." We also observed people were asked for their consent and were supported in ways that were respectful. For example, we heard one care worker say, "Is it ok for me to put this apron on you to keep your clothes clean while you enjoy your lunch?" The person responded by smiling.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us about 'best interests' decisions and that they were following the principles of the MCA. For example, one staff member spoke with us about whether or not people living in the home had capacity to make their own decisions. They said, "[Person's name] can make her own decisions, so can [another person's name]. But, for those who can't, you have to give choice, make a decision based on what you think they might like or want based on what you know about them." Another staff member told us, "You always ask before you start helping someone. Even if someone has dementia you have to try and get permission." Staff we spoke with also told us they would involve senior staff and other professionals for bigger decisions where people might lack capacity.

People's care records showed their capacity to make particular decisions had been assessed in line with the MCA. However, some of these were not up to date and this made it difficult to establish what support people might need with decision making. This was particularly the case for those people whose care plans had not been reviewed for some time. These were not always clear, and decisions which appeared to have been made in people's 'best interests' were not always well recorded. For example, there were a number of people who had bed rails in place. Where people did not have capacity to choose to have bed rails, some care plans included up to date risk assessments, alongside information on the person's decision-making ability and discussions with others which concluded bed rails were in their best interests. However, some of these were dated 2014 for example, and had not been reviewed, while others did not include information on how the decision [to have bed rails] had been reached and with whom. We spoke with the manager about this, who pointed to a number of examples where the decision to have bed rails was clearly recorded, and had, for example, formed part of a referral the home had made to deprive someone of their liberty. They assured us where this was not the case, people's care plans would be reviewed as soon as possible.

The manager understood their responsibilities under the DoLS legislation. They had identified people who were lacking in capacity to make particular decisions and had restrictions in place, and had made the appropriate applications to the local authority to have this assessed. Records showed they had sought advice and guidance from the local authority recently regarding having a locked door, and had acted on the

advice they had been given. However, whilst applications had been made to deprive people of their liberty, these had not always been followed up with the local authority where delays in assessing people had been experienced. For example, we saw two DoLS applications had been made, and there had been an 'urgent' authorisation in place to deprive someone of their liberty. However, this had expired which meant the provider could not be sure restrictions in place were lawful. We spoke with the manager about this, who took action to ensure they sought advice on this from the local authority.

People living with dementia were now having their needs met much more effectively. Prior to this inspection, we had found people living on Birch unit [which had been designated at the part of the home where people with dementia were supported] were not well supported. They did not leave the unit, even where this would have been of benefit to them. This often meant people had limited space in which to move around, and had limited interaction with other staff and people living at the home. On this inspection, we found the doors to the unit were now open, and that some people living with dementia had been reassessed and were now integrated into the whole of the home. This gave people the opportunity to have more space and interactions with others, and enhanced the level of support they experienced. The manager told us this meant people with dementia had much more involvement in activities, as well as day to day interactions which they aimed to continue to improve.

Staff received training suitable to support people with their health and social care needs. Most staff we spoke with told us they had received basic training to help them keep people safe and well. The manager acknowledged there were some gaps in training, particularly training for staff on how to safeguard people from harm and abuse. Records were incomplete and were not clear, so it was not possible to tell which staff had been trained and when. Following our inspection, the manager ensured extra safeguarding training was arranged to ensure all staff were aware of their responsibilities.

Staff had the opportunity to undertake training to enhance their skills so they could support people more effectively. One staff member said, "I have done my level one diploma, and I am now moving on to my level two. I have also done MAPPA training (this is training intended to help staff deal with situations where people are physically aggressive), which was very good as you can see how you can protect yourself and other people."

Staff were positive about the training they had received. One staff member spoke about some first aid training they had undertaken recently. They commented, "If anyone is in need, you know you can help them." Staff also spoke about dementia training. One told us, "It is often about doing activities with people. People need stimulating and more interaction." Another staff member commented, "You need to show people you understand….to make people feel better about themselves."

Staff who had recently started working at the home had not always received an induction. One staff member told us, "I left and today is my first day back. I was under the impression I was coming in to do an induction. I expected to shadow someone and get back into it, but I turned up and I'm on shift." The manager told us how induction should be managed. They told us Care Certificate workbooks were now being used with staff who were new to care. They explained the provider is using an external consultant to assess new starters against the Care Certificate, and that they would need to be signed off as competent before being confirmed in post. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff had regular individual and team meetings with the manager. Staff said they valued these meetings and saw them as an opportunity to discuss any concerns and opportunities that led to their own and the home's

development. One care worker said, "They [Individual meetings] are a good way of seeing where you're at, things you are doing well or anything you should be doing which you're not."

People told us that, on the whole, staff were competent and supported them as they should. One person said, "I am always well looked after by care staff." Relatives had mixed views. They told us most staff were competent and were effective in their roles, but they did not always feel staff communicated with each other effectively. One relative commented, "Generally nurses are very good. Communication between them could be better. I recently witnessed a patient who had had a stroke, a lovely new male nurse came to help them and sort them out and then took their blood pressure but didn't know that they had a stroke and wrapped the blood pressure pad around the wrong arm. The regular nurse never told him the situation. There should be hand-overs. It would make a difference."

Staff told us they had the opportunity to talk to senior staff when they needed to about issues relating to people's care, but they were not always sure who they should talk to and in what circumstances. Some staff told us this was clear when the manager was on shift, but that when they were not, they had not always received helpful responses from senior staff.

People told us they were happy with the choice of food on offer. One person said, "There's a good choice of food." Another person commented, "I get a good hot cooked breakfast every day, lunch with two meat choices and fish on Friday." Where staff supported people to eat, this was done in an unhurried manner, staff described the food to people, frequently checked that the food was not too hot at the beginning of the meal and then checked that it had not cooled too much. One care worker was supporting a person with eating their breakfast. The care worker said, "Hello [Person], that's a lovely smile are you ready for your breakfast. Perhaps we can sit together and I can help you." The person "nodded" and was encouraged and assisted to eat their meal at a relaxed pace. Throughout the day we observed people were offered drinks and snacks. There was a menu on display in the dining area. This indicated a choice of foods available, and we saw people were able to choose alternatives.
In March 2016, we found risks to people's nutrition and hydration were not always minimised effectively. Whilst risk had been assessed, actions to minimise risks were not always indicated, and records to monitor food and fluid intake and weight loss were not always completed. At that time, we also spoke with a dietician who expressed some concerns that dietetic care plans were not being followed. During this inspection we found there had been some improvements. Some people had up to date risk assessments in place. However, other care plans that had not been reviewed, still included risk assessments around food and fluid intake that were not clear or up to date. Supplementary records intended to monitor food and fluid intake were now being completed, and most now identified how much food and fluids people should be taking per day. However, some people's records had gaps in them, so it was not possible to check how much food and fluid they had taken. Weight monitoring records were also incomplete. It was not always clear how often people should be weighed, or whether action had been taken as required in response to weight loss.
We looked at the records of one person who was at high risk of weight loss. Records were not clear on how much food the person had eaten, and staff we spoke with, including kitchen staff and a lead nurse, were not aware of how to ensure the person's nutritional needs were met. We raised this with the manager, who assured us action would be taken to address this. Shortly after the inspection, we were told the dietician had been contacted and had provided clear guidelines for staff to follow to ensure the person's nutritional needs were met. The manager also shared some written feedback they had received from the dietician following our inspection. This indicated the dietician had noted recent improvements in the accuracy and frequency of weight monitoring, and felt the manager had effective plans in place to prioritise nutrition within the home. The manager had also arranged for kitchen staff, along with staff identified as nutrition 'champions' in the home, to attend training on the fortification of food.

People told us they saw external health professionals when they needed to. "I see a chiropodist every three weeks and an optician where I purchased some new glasses." Relatives we spoke with told us they went to nurses if they were concerned about their relative's health. One relative commented, "[Relative's name] had a skin problem and it was sorted out through the nurses, we didn't see the GP." Care records showed people accessed health care services such as GP's, dentists, district nurses and chiropodists when needed.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were kind and caring and treated them with respect. However, some relatives felt staff did not always have time to interact with people in ways that promoted their well-being. One relative said, "The home's staff are very friendly and they want to do their best, but they struggle to get done what needs to be done in the time they have." Another relative commented, "The permanent staff are very good. They try very hard but it can be difficult because they are always rushing around." During our inspection visits we saw examples of where staff interaction and attention to people's needs offered them reassurance and comfort. We also observed people were asked for their consent and were supported in ways that were respectful. For example, we heard one care worker say, "Is it ok for me to put this apron on you to keep your clothes clean while you enjoy your lunch?" The person responded by smiling.

Staff told us what being 'caring' meant for them. One staff member told us, "It's helping a person, protecting them, and promoting what they can do for themselves. Sitting, talking and being kind." A nurse described caring as being sensitive, and showing kindness and concern. We observed some kind, respectful and friendly interactions between people and care staff. For example, one care worker sat gently stroking a person's hand giving them verbal reassurance because the person seemed to be upset. The person responded positively to this. We saw one person put their arms around a staff member. The staff member said, "That's a lovely cuddle. Would you like to walk with me? Perhaps we could have a nice chat." Whilst staff knew how their interactions with people could promote well-being, and we did observe examples of this, the ways in which staff were deployed and the pressures on their time, meant it was not always possible for staff to fully enact this.

People's care plans contained limited information about people likes, dislikes, preferences and history. However, some plans had been recently reviewed and did contain some of this information, although it was brief. We spoke with the manager about this, who told us they were focussing on ensuring all care plans were reviewed and updated to ensure staff had the basic information they needed to support people safely. They told us they planned to further develop care plans once this initial process had been completed, to ensure they were more personalised.

Staff told us they understood the importance of respecting people's privacy and dignity and we saw people were supported to private areas of the home when they needed help with personal care. One care worker said, "I always ensure only the staff who are needed stay whilst we assist someone with personal care. If they have a visitor I always ask if they would mind stepping outside for a minute." We observed a nurse inviting a person to return to their bedroom so medical assistance was given in private.

People were supported to maintain relationships with family and friends. Relatives told us they visited people on a regular basis, and that they were made to feel welcome. One relative told us, "It's lovely coming to visit now."
Staff spoke clearly and calmly to people, and encouraged them to do things for themselves. One person made it clear they wanted to eat independently, but took a long time to do so. Staff respected the person's wishes and did not try to intervene.

We observed people's care plans were kept securely and were only accessed by those who needed to access them. This helped to ensure people's privacy and dignity was maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2016 we found people were not supported in a person centred way, and their care was task focussed and not focussed on the needs of individuals.

During this inspection we found the provider had taken some steps to review and reassess the needs of people living in the home to ensure they received person centred care and support. However, we found this work was not complete and more needed to be done to achieve this. We found the provider was not always responsive to people's assessed needs, and that staff did not always have the information they needed to support people consistently and safely. Staff we spoke with agreed care plans did not always give them the information they needed. One staff member told us, "Care plans still need a lot of work. They don't always take into consideration the needs of the resident. At the end of the day it should be about the care that person needs. If [manager] had the right support they could do that [ensure care plans were up to date]."

A number of care plans had been reviewed and were up to date. Where this was the case, staff had access to information they needed to support people according to their individual needs. Immediately following our inspection visit, the manager sent us information that indicated all but twelve care plans had been reviewed and updated. However, where care plans had not been reviewed, staff did not have clear information about people's personal needs and preferences, and where they had health conditions, up to date information was not always available to staff. For example, we observed one person 'chasing' some food around their plate, they were sitting in an armchair with a small table in front of them where their lunch had been placed. We obtained a plate guard from the main kitchen and they were able to finish their food independently. There was no detailed care plan surrounding the need to use aids to assist with eating, no indication of fluid or dietary needs, or how to support the person with diabetes in managing their health, diet and related medicine.

Staff did not always have up to date and accurate information about risks to people's health, safety and well-being. This made it difficult for people to be supported in ways that were important to and for them. We raised this with a senior nurse on duty as this posed a risk to the person's health and well-being, and they assured us the person's care plan would be updated immediately.
People who had skin problems such as wounds or ulcers had records kept in relation to their conditions. However, the quality of the records varied considerably. We found some of these records contained generalised information about how to protect people's skin where they had been assessed as being at risk. However, they did not always contain information for staff on how this affected the person individually, and it was not always clear what had been recommended for the individual. However, we did see staff were supporting people with pressure relieving equipment and that, where necessary, assistance had been sought from medical professionals.
For example, one person's care plan we reviewed included information and guidance for staff on how the person's skin needed to be protected. Their care records showed there had been contact with the GP and that the person had been referred for more specialist intervention. Recommendations included that the person's wound be dressed regularly, and pain relief administered. These were clearly recorded in the person's care records. On the day of our inspection, we noted a clinical issue in relation to this person's care.

We spoke with nursing staff about this, who assured us the issue was being dealt with, and that follow up contact with specialist medical staff was already planned.

This was a continued breach of Regulation 9(1) (a) (b) (c) HSCA (RA) Regulations 2014 Person Centred Care.

People we spoke with told us they were not directly involved in putting together and reviewing their own care plans, but that their relatives were. Most relatives we spoke with told us they were involved in reviewing care plans to ensure they were up to date. Relatives would be involved with the person's permission, to ensure involvement from as many people as possible in order to give a rounded picture of people's care needs.

At our last inspection in March 2016, we found there were not always activities taking place that people wanted to join in with, and that people living with dementia and being supported on Birch unit were neither offered nor engaged in activity. At this inspection we found the provider had taken action on this, and that a range of activities were now on offer, including to those who were supported on Birch unit. One person commented, "I get my nails done and I have had aromatherapy here."
Relatives also told us opportunities for people to take part in meaningful activities had improved. One relative said, "It's good to see people on Birch being included in activities. This never used to happen."
During our visit we observed a group activity in the large lounge. An external entertainer who was leading the activity ensured each person was asked if they would like to join in and their choice was respected. We saw people who were engaged in the activity enjoying this and the room was filled with chatter and laughter. We were also told other activities took place. We observed this activity moved around the home to other communal areas so people had the opportunity to take part if they wanted to.
Whilst we could see there were a range of activities available on different days, some people told us they were not aware of what was on offer. We observed there was an activities board on display which detailed what was happening in the home and what people could join in with. However, this was situated in a corridor near to the home entrance, and so it was only accessible to a small number of people living in the home. The manager and activities co-ordinator agreed to consider moving this to a more obvious location so people could see it.

At our last inspection in March 2016, we found the provider did not do enough to respond to complaints and concerns raised by people, and did not learn from them in order to improve the service provided. During this inspection, we found that improvements had been made, and the manager had taken some action to ensure they received, handled and learnt from complaints and concerns raised by people.

The manager had introduced a 'comments notice-board' where people and relatives could leave notes on to feedback what they thought the provider did well, as well as areas of concern. Relatives we spoke with told us they had seen improvements where they raised concerns. One relative commented, "I always use the Complaints Board and it gets sorted immediately by [manager]." Prior to our inspection visit, information we received about the provider, indicated that relatives had made complaints and these had been resolved to their satisfaction.

Records showed complaints had been logged and responded to, and that the manager was using that information to make improvements to the service. However, the manager acknowledged that further improvements were required. One relative told us they had raised a concern when the manager was on leave, and that they were told nothing could be done. Whilst they explained the manager had resolved the matter on their return, they told us they had been concerned by the initial response. The manager told us they were working to ensure people and their relatives received consistent responses from staff no matter when the concern was raised. The manager was working with the provider to recruit a deputy manager to

help with this.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in March 2016, we found systems to monitor improvements were inconsistent and ineffective. There had been further management changes and we found the provider had little oversight of the service, and did not have effective measures in place to check how the home was being managed.

At this inspection, a new manager had been in post since April 2016. The manager had formulated an action plan, and had recognised a range of issues that needed to be addressed, and had established work programmes to achieve this. The provider also now ensured effective auditing and quality checking was taking place, which meant they had better oversight of the service being provided. People, relatives and staff reported improvements in management and leadership, and we found the provider was no longer in breach of the regulation, and the warning notice had been met.

All the people and relatives we spoke with said the new manager was making improvements to the service. Relatives told us the manager was approachable and responded to any concerns raised. One relative told us, "[Manager] is doing a good job, is open and will listen. They are very good at taking action when you raise issues. They put things in place straight away to deal with any concerns." Another relative said, "I have definitely seen improvements since [Manager] started."
Staff told us they felt supported by the manager. One staff member said, "[Manager] is very approachable, which is good. Anything you raise is dealt with." A Nurse said, "It's important to feel supported and to have a manager who gives clear direction which is what we have."

The manager told us they had an 'open surgery' every week, which was well advertised so that people and relatives could come and talk to them about any concerns they might have. They felt this made them approachable and responsive. During our inspection visits we observed the manager talking with people, staff and relatives. They ensured they were visible around the home, and we saw people responded positively when conversing with them.

Staff told us they had noted improvements since the manager began working in the home. For example, one staff member told us, "The paperwork is so much better now. It is so much easier to understand. The daily notes, the charts we complete. It is all working better than before." Another staff member told us how the manager had listened to staff concerns and had taken action as a result. They commented, "Helping people with personal care is much better now in the mornings. There were so many people who needed support in their rooms it was difficult. Now, staff are being used better. That has helped."

Staff told us they met regularly as a staff team which gave them the opportunity to contribute ideas and discuss their views. One staff member said, "We have staff meetings every six weeks or so. [Manager] tells us where we are, what we can do to improve. They will ask people about any concerns they have so everyone has their say. I like the staff meetings. You can air your views. Things do get dealt with."

The provider ensured the service was checked by an external person who completed audits and quality checks. These checks had identified many of the issues we picked up during our inspection, such as care

plans needing to be reviewed. This had led to the development of an action plan which the manager was working towards. However, these checks had not picked up on all the issues we found, such as DoLS applications needing to be followed up with the local authority. We spoke with the registered manager about this, who told us they felt confident as the rolling programme of reviewing people's care plans progressed, these issues would be picked up as part of that process.

Relatives and staff told us that, whilst they had noted improvements once the manager had started working at the home, they had some concerns about what happened when the manager was not in the building. One relative explained the manager has instructed staff to undertake regular checks on their family member which had not been completed when the manager was not in the home. The relative told us, "I arrived on Sunday to find Mum in bed. I just want the best for my Mum." Relatives told us whilst improvements were being made they still felt the need to regularly visit their family member to ensure they were being cared for. One relative said, "You have to constantly be on the ball making sure they [Staff] are doing what they need to for [Person]." Another relative said, "I still visit all the time because I worry about what goes on when I'm not here."

Staff members also told us of their concerns about what happened when the manager was not in the home. One staff member commented, "There are problems when [manager] is not here. When [manager] is here, things run smoothly. The deputies need to be respected like [manager]."

We spoke with the manager about the concerns raised on when they were not in the home. They told us they had also identified this as an issue, and that the current arrangements where two senior members of nursing staff were acting as deputies was not providing the continuity and oversight they had hoped for when they were not in the home. They explained they had spoken with the provider about this, and were already actively recruiting a dedicated full time deputy manager to ensure consistency and leadership across the week. They acknowledged there was still work to do to ensure all staff were committed with what they were trying to achieve, and felt the support of a dedicated deputy would assist with this and allow the manager to focus on further developments and improvements.

The manager told us the provider was fully committed to the improvements that needed to be made, and was supportive to them. They also told us the provider was responsive to requests for support and resources the manager and auditor had identified as being necessary for the service to develop and improve.

The manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months.

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 Regulation 9 (1) (a) (b) (c) HSCA (RA) Regulations 2014 Person-centred Care The care and treatment was not focused on, and did not meet the needs of, each person. Service user's individual needs had not been assessed to ensure they were appropriate, or that their preferences had been taken into account.