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Malvern Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

.Malvern Nursing Home provides accommodation and nursing care for a maximum of 28 adults with complex mental health needs. The service is located in a residential area of Bradford approximately two miles from the city centre.

We inspected Malvern Nursing Home on 17 and 30 November 2016. Both visits were unannounced. There were 19 people using the service when we inspected.

Our last inspection took place on 12 May and 22 June 2016 and at that time we found the home was not meeting five of the regulations we looked at. These related to safe care and treatment, dignity and respect, meeting nutritional and hydration needs, person centred care and good governance. The service was rated 'Inadequate, and was placed in special measures. This inspection was therefore carried out to see if any improvements had been made since the last inspection and whether or not the service should be taken out of 'Special measures'.

Following the last inspection we met with the registered provider and they informed us they were still committed to appointing a Registered Mental Nurse (RMN) to become the registered manager and improving the standard of care and facilities provided. They also told us they intended to employ a consultant to assist them to achieve compliance.

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 the registered provider told us although they had appointed a manager they had resigned after only a short period of time and they had re-advertised the post. They confirmed in the absence of a manager the recently appointed deputy manager would manage the service on a day to day basis assisted by the clinical lead nurse and assistant manager.

We found the care plans in place did not always provide accurate and up to date information and in some instances nursing staff had completed monthly care plan evaluations without making sure the care plan was still relevant to the person's needs. We saw individual risk assessments which identified specific risks to people's health and general well-being, such as falls, mobility, nutrition and skin integrity. However, we found they again did not always provide accurate and up to date information. This might lead to people receiving inappropriate care, treatment and support.

We also found that although medication policies and procedures were in place nursing staff did not always following the correct procedures which meant we could not be confident people received their medicines as prescribed.

We saw people were offered varied a range of homemade meals and a new dining room had been created which made mealtimes a more relaxed and enjoyable experience for people. People told us the food was good and our observations confirmed this. However, we had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient.

People told us they were happy living at the home and we saw some caring interactions between staff and people living at the home. We found more emphasis had been placed on treating people with dignity and respect and staff encouraged people to take more pride in their appearance. We also found the registered provider was trying to change the culture within the staff team and stop the institutional practices observed at previous inspections.

We found although external consultants had been employed improvements were still required to the quality assurance monitoring systems in place as they were not robust and had not always identified the shortfalls in the service highlighted above and in the body of this report. The registered provider was not always able to demonstrate the service was managed effectively and in people's best interest.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act 2005 (MCA).

We saw the complaints policy had been made available to everyone who used the service. The policy detailed the arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, meeting nutritional and hydration needs, person centred care and good governance. These were continued breaches from the last inspection. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

We found the overall rating for the service remained 'Inadequate' and therefore the service remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Medicines management was not safe and effective, which meant we could not be confident people received their medicines as prescribed.

Risks to people's health, safety and welfare were not always properly assessed and mitigated. Some risk assessments did not provide accurate information or had not been updated.

Is the service effective?

Requires Improvement

The service was not consistently effective

Concerns we raised at a previous inspection in relation to nutrition remained as the provider had failed to address these shortfalls.

Staff were supported to meet people's needs by means of a planned programme of staff training, supervision and appraisals.

The location was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were referred to relevant healthcare professionals if appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring

People told us they were happy with the care they received and we observed some caring interactions between staff and people.

People's appearance suggested they were now being supported and encouraged to maintain the standard of cleanliness they

should expect. However, we found staff did not always pay enough attention to detail when dealing with people's personal clothing.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Although care records completed for people's mental health provided detailed information, the care records relating to people's physical health did not always provide accurate and up to date information.

There was a programme of social and leisure activities both within the home and the local community which people told us they enjoyed.

A system was in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led

There was a lack of consistent management which had impacted on the ability of the service to improve.

There were quality assurance monitoring systems in place which were designed to identify any shortfalls in the service and non-compliance with current regulations.

However, the governance systems were not robust or consistently applied therefore we could not be sure the service was managed effectively and in people's best interest.

Malvern 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 17 and 30 November 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor [Mental Health].

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We looked at people's care records, medicines administration records (MAR) and other records which related to the management of the service such as training records, staff recruitment records and policies and procedures.

We spoke with six people living in the home. We also spoke with the registered provider, the deputy manager, the assistant manager, the clinical lead nurse, one qualified nurse, four staff members, the activities co-ordinator and the cook.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications the registered provider had sent us.

We usually ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the registered provider to complete a PIR on this occasion.

Inadequate

Is the service safe?

Our findings

At a previous inspection in May 2016 we found a regulatory breach in relation to medicines as nursing staff did not always follow the correct procedures when administering medicines and medicines were not always administered as prescribed.

At this inspection we saw medicines were administered to people by nursing staff. We were told people were assessed as to their capability to self-medicate and observations of care plans showed this to be the case. We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found MAR and associated records were on occasions incomplete.

We observed the morning medicine round conducted by a registered nurse and saw them administering medicines in a manner which did not comply with the prescriber's instructions. For example, some people were prescribed medicines which had to be administered before, with or after food. We found these instructions were not being followed. We saw two people were administered Lansoprazole after breakfast whilst the instructions showed the medicine should have been administered 30 to 60 minutes before food. We also saw Glimepiride administered after breakfast whilst the instruction was to administer the medicine before or during the meal.

Whilst we were told all 'as necessary' (PRN) medicines were supported by protocols to guide staff in the consistent administration of medicines our observations found no evidence of protocols with the MAR sheets. In a separate file we found some old protocols which showed these had been a feature in the past. Examples of unsupported PRN medicines included the following. One person was prescribed Paracetamol 500mgs to take two tablets 'as directed'. We saw the medicine had been administered but no record existed of the effect of the medicine. We saw a person was prescribed Chlorpromazine 100mgs three times a day and Chlorpromazine 50mgs PRN. We saw the PRN dose of 50mgs had been administered at the same time as the morning administration of 100mgs yet no protocol existed. Furthermore the MAR sheet together with an audit of stock levels indicated one PRN dose of Chlorpromazine 50mgs had been administered between the 8th and 15th November 2016 but had not been recorded.

We saw a person was prescribed Paracetamol 500mgs PRN up to four times a day but no protocol existed. We saw on the 3 November 2016 the MAR recorded the administration of two Paracetamol 500mgs tablets at 08.30hrs. However the stock balance of the 2 and 4 November 2016 both showed a stock balance of 93 tablets which suggested the medicine had not been administered, or at least had not been administered from that supply.

We saw on one occasion the MAR was handwritten. The MAR sheet recorded Haloperidol 1.5mgs to be administered twice daily but the boxed medicine recorded the medicine to be administered on a PRN basis up to twice daily. The medicine had clearly been administered on a PRN basis but no protocol existed. The handwritten MAR was only signed by one person and therefore the error had not been checked by a second person. The National Institute for Health and Care Excellence (NICE) guidance on 'Managing medicines in

care homes (March 2014)' was filed in the clinic room and we were told the home adhered to the guidance. However recommendation 1.14.9 states that handwritten MAR sheets should be checked for accuracy by a second trained and skilled member of staff before it is first used. This was not being adhered to.

We found errors in the recording of medicines and some evidence medicines were not being administered as prescribed. For example, we saw one person was prescribed Clozapine 100mgs twice a day and Clozapine 25mgs at tea time. We saw no signature for the tea time administration of Clozapine 100mgs on 30th October 2016 and stock level recording made it difficult to check whether the medicine was administered. There were two further gaps in signatures for the 14 and 15 November 2016 however stock level recording and our own audit of stock levels suggested the medicine was administered on these dates.

We observed one person was prescribed Procyclidine 5mgs with the instruction 'Take one when required three times a day'. We saw no evidence of a PRN protocol to guide staff in the administration of this medicine. However the clinical lead nurse told us it was prescribed for drug-induced Parkinsonism but they found the medicine had little effect. The MAR showed the person was prescribed Amisulpride 600mgs twice a day (a dose at the upper end of the recommended range), a neuroleptic drug which may induce Parkinsonism. We observed the person to have a pronounced symmetrical hand tremor. We saw no evidence in care plans that the nurse's opinion of the ineffectiveness of the Procyclidine had been discussed with a doctor. We asked the clinical lead nurse how it could be assumed the medicine was ineffective when it had only been administered on four occasions in the past 23 days. We were told this had been apparent before the current MAR sheet was commenced. This further indicated the apparent ineffectiveness of the medicine had been known for some time without any action to alleviate the person's symptoms.

Furthermore the MAR sheet file contained a 'Patient Notes' form which required nurse to record when PRN medicines were administered, for what reason and the effect. We found no record for the four occasions Procyclidine was administered therefore neither we nor any doctor reviewing the need for the medicine had any documentary evidence to support or refute the need for the medicine.

We looked at MAR with regard to the prescribing and application of creams and lotions. We saw four people were prescribed creams. On all four occasions the application of creams was not being recorded on the MAR. We asked the deputy manager if topical MAR sheets existed elsewhere to enable care staff to record the application. We were told topical MAR sheets did not exist. We therefore could not be confident the creams were being applied as prescribed.

We conducted an audit of medicines supplied in boxes. Whilst we found some medicines dispensed in boxes had not been administered we were able to account for the stock we audited.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs could be accounted for.

We looked at two recent audits of medicines conducted on 4th October and 19th October 2016. The earlier audit found shortfalls in the safe and effect management of medicines. The audit recorded PRN medicines were not being recorded when refused, the fridge door was unlocked and room and fridge temperatures were not being recorded. The later audit showed PRN medicines were still not being recorded when refused, signatures were missing from the MAR sheet, staff were not recording the effect of PRN medicines and the fridge remained unlocked when not in use. Our observations of the service conducted over four weeks after the last audit showed no progress in the management of medicines. We concluded audits conducted at the home were having little if any effect to drive forward quality improvements.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider's staff recruitment procedure had not always been followed. On this inspection we looked at two staff recruitment files and saw all relevant checks had been completed. This included obtaining two written references and a criminal record check through the Disclosure and Barring Service (DBS) before new employees started work.

The provider told us sufficient staff were employed for operational purpose although they were recruiting for qualified nurses and male care staff. However, the staff rota showed only three qualified nurses were permanently employed at the home and a bank nurse. The registered provider told us of the three permanently employed nurses employed one had recently given one month notice and was therefore due to leave the home during December 2016. The registered provider confirmed two nurses had left following the last inspection and they continued to have difficulties recruiting qualified nursing staff. This meant the service was running on minimum staffing levels for qualified nursing staff and were reliant on agency nurses to cover the shortfall in hours. The provider confirmed wherever possible the service employed the same agency staff to ensure people received continuity of care.

The staff we spoke with understood what may constitute abuse and knew how to protect people from avoidable harm. They told us they had attended training and were able to explain their responsibilities with regard to keeping people safe. They were aware they could report suspected abuse externally to the Local Authority and CQC.

At the last inspection we reviewed risk assessments completed for individual people in areas such as moving and handling, nutrition, falls and the prevention of pressure damage to the skin. We found some assessments were well completed but found there were discrepancies in others we reviewed. On this inspection we still found discrepancies in the documentation we looked at. For example, one person had a moving and handling assessment dated 04 May 2016 which stated it should be reviewed every 12 weeks. The last recorded review was 21 June 2016 which meant it was almost two months over the review date when we visited. In the same person's records there was a risk assessment for outings which was not dated and a falls risk assessment which had not been reviewed since August 2016.

We asked the cook about the use of a thickening agent which had been prescribed for one person who used the service to reduce the risk of choking. The instructions on the tin stated to use 'as directed'. The cook told us they added one and a half scoops to 200mls of fluid. We looked in the person's care records. The nutrition care plan dated 14 March 2016 stated the person's drinks should be thickened to 'syrup' consistency but did not provide any details on how to achieve this consistency. When we looked at the care plan on the first day of our inspection the last recorded review was dated 20 August 2016 and although the review made reference to the thickening powder it did not highlight the lack of specific instructions about its use and the care plan was not updated to include this information. On the second day of our inspection we found two further reviews had been recorded, one dated 23 September 2016 and the other dated 11 November 2016. The September review stated the person was now having a milk shake to build up their weight but the care plan was not updated to include this information. In addition we found no changes had been made to the care plan following the November 2016 review.

We saw another person who used the service also had a tin of thickening powder on which the label stated it should be used 'as directed'. The cook told us they used a similar amount, one and a half scoops to 200mls of fluid. We looked in the person's care records and a report from a Speech and Language Therapist dated 8 August 2016 which stated staff should use one scoop of thickener to 100mls of fluid to achieve a syrup

consistency. This information was not in the person's care plan which meant staff were not aware of the correct consistency.

In another person's records we saw a Waterlow assessment (to assess the risk of developing pressure sores) had been completed on 1 November 2016 and scored 19 which indicated a high risk. There was no care plan in place to show what action was being taken to manage the risk. One of the care staff told us the person had a pressure relief mattress on their bed but they didn't know anything about the setting. On the second day of our inspection we looked in the person's room and saw there was an air mattress in place and it was set at '30'. Another member of care staff told us this was the setting the person found most comfortable. We asked how they knew the setting was correct and they said they had been given the information by the nursing staff. However, there was no information in the person's care records about the mattress setting.

We completed a tour of the premises and inspected five people's bedrooms, toilets, bathrooms, the laundry and various communal living spaces. All hot water taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by hot water or electric radiators; whilst most radiators were covered or of cool panel design we saw three radiators were uncovered and posed a risk to people. We also found the window restrictor in one bedroom was broken which allowed the window to fully open. These issues were discussed with the registered provider. Following the inspection we received confirmation from the assistant manager that the window restrictor had been replaced, the electric radiator had been reset with a maximum temperature and other radiators in the home had been checked. We saw since the last inspection the provider had extended the emergency call systems to ensure everyone who lived at the home had access to an emergency call lead when in their bed.

We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed. We found all floor coverings were appropriate to the environment in which they were used; were well fitted and as such did not pose a trip hazard. We inspected records of the lift, gas safety, electrical installations, water quality and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient. For example, we had looked at one person's care records and were unable to determine their height and weight because the information was contradictory. We had brought this to the provider's attention so that it could be addressed. During this inspection we checked the person's records and found this had not been done. One document stated the person's height was 5' 5", another stated it was 6' 1" and a third stated it was 5'7".

The same person's nutritional assessment had last been reviewed on 18 August 2016 and this indicated there was 'cause for concern' about their nutritional status. However, the assessment had not been reviewed since August 2016. Similarly the person's care plan for eating and drinking had not been reviewed since 18 August 2016. We also found that although the care plan was dated 15 August 2016 there were care plan reviews dating back to March 2016 and all the reviews stated the same thing. This suggested the care plan review process was not a proper review of the effectiveness of the care plan in supporting the person to meet their nutritional needs.

In the same person's records we saw they had a weekly weight monitoring record however, their weight had not been recorded weekly. For example, no weight had been recorded for September 2016 and only two weights had been recorded in October 2016. The deputy manager showed us a piece of paper which stated the person's weight was recorded as 74kg in November 2016. However, on the second day of our inspection the deputy manager was unable to locate this piece of paper and the most recent weight recorded in the person's records was 23 October 2016.

In another person's records we saw they had an eating and drinking care plan dated 13 August 2016. The recorded care plan reviews pre-dated the care plan the most recent being 29 July 2016. When we looked at the person's weight records we found fluctuations in their weight which had not been addressed in either the care plan or the nutritional assessment which had not been reviewed since 29 July 2016. The person did not have a MUST (Malnutrition Universal Screening Tool) assessment. The weight records in the person's care file showed their weight had last been checked on 2 October 2016 and was 74.kg. Their weight on 17 July 2016 had been recorded as 79.4kg and on 21 May 2016 as 83kg. This meant the person had lost 8.9kg between May and October 2016. On the first day of our inspection the deputy manager showed us a piece of paper which stated the person had been weighed on 28 August 2016 (80.5kg) and 2 November 2016 (77.2kg). However, when we looked in the person's records on the second day of our inspection this information had not been included in the person's individual records and the deputy manager was unable to locate the piece of paper.

On the second day of our inspection we saw the person's care plan had been reviewed on 22 November 2016 but no changes had been made. In addition, we found the nutrition assessment had not been updated and a MUST assessment had not been carried out. Following the last inspection of the service in May 2016 the provider was made aware of concerns about the way this person's nutritional needs were being addressed. Our findings during this inspection showed those concerns had not been dealt with.

We looked at the records of another person whom the deputy manager told us was nutritionally at risk. We found a nutritional risk assessment had not been completed. The person had an eating and drinking care plan dated 17 August 2016. The objective of the care plan was to 'ensure [person's name] maintains a stable and steady weight and a healthy BMI' however there was no target weight recorded. It wasn't clear how often the person's weight was to be checked, the care plan stated two weekly but someone had drawn a line through the two giving the impression the person's weight should be checked weekly and there was a weekly weight monitoring form in their records. However, this showed the person's weight had not been recorded in September and there were only three entries for October 2016. The person's dietary intake was being monitored and there were fluid and food charts in place. However, when we looked at the fluid and food charts we found they did not include enough detail to provide an accurate picture of what the person was eating and drinking.

For example, on the record dated 12 November 2016 there was nothing recorded until mid-afternoon. The tea time entry showed the person had eaten sausage rolls and beans with ice cream for dessert but there was no quantity recorded. The record for lunch time on 13 November 2016 stated 'Sunday meal and pudding' but did not include any more details. We looked at the charts covering a period of seven days and found similar entries. We also found the daily fluid intake was not being added up and there was nothing to show the charts were being monitored to check either that the person was receiving adequate food and drinks or that staff were completing the records properly. We looked at the fluid and food charts for another person and found the same issues.

In another person's records the care for eating and drinking dated 31 January 2016 stated the objective was to 'maintain my current weight of 113.9kg." The care plan was last reviewed on 20 August 2016 and stated the person was eating and drinking adequately at meal times. The person's weight record showed their weight had last been checked on 17 July 2016 and was 101.7kg which represented a weight loss of 12.2kg. There was no information in the care records to indicate anything had been done about this and when we asked the nurse in charge they told us they were not aware of the weight loss.

We found people's weights were routinely being recorded on three different forms which increased the possibility of mistakes being made in recording them correctly. For example, we looked at the weight record for one person on permanent bedrest and found on the 20 August 2016 their weight was recorded on the Malnutrition Universal Screening Tool (MUST) as 60.5KG. No weights were recorded on the form for September and October 2016 but when they were weighed again on the 3 November 2016 their weight was recorded as 49.KG. A second monthly weight record showed their weight on 2 October 2016 as 49.Kg and on the 2 November 2016 as 39Kg whilst a third weekly weight record showed their weight on the 11 November 2016 was 47.3Kg. There was evidence the person had been seen by a Speech and Language Therapist (SALT) on the 8 August 2016 and was taking diet supplements. This matter was discussed with the deputy manager who acknowledged the discrepancies had not been identified by the senior staff team or brought to their attention by staff.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we had found people had a poor dining experience and were not encouraged to retain their independence as staff did everything for them including buttering their toast and putting sugar and milk in their drinks prior to them being served. We concluded this not respect people's individuality and the culture within the staff team meant they just followed the daily routines without ever questioning why they were in place, or if there was a better way of working.

We saw on this inspection a new dining room had been created and in what was one of the lounge areas. The dining room provided people with a much improved dining experience and there was now a weekly menu on display. We also saw provision had been made for people who were able to serve themselves at certain mealtimes. We observed the lunchtime meal and found the atmosphere was informal and relaxed. The deputy manager told us they had started to change the culture within the staff team and more emphasis was now being placed on assisting people to retain and develop their self-care skills.

We spoke with the cook who had a very good understanding of people's cultural and dietary needs and ensured people were offered a varied range of homemade meals which included a meat and vegetarian curry every day as well as other main course choices. People we spoke with told us they enjoyed the food served and using the new dining room. One person said, "It's much better now, I can get what I want and the dining room is so much better than the old one it's like eating in a café, I really like it." We saw at the lunchtime meal there was a choice of food and people were offered second helpings.

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 saw five people were subject to DoLS authorisations and of these three had conditions attached. We saw from care plans the conditions had been incorporated into the plan and had been subject to regular review however there appeared to be a reduction in the frequency of care plan reviews from August onwards. We saw three further applications had been submitted to the supervisory body and were awaiting authorisation.

The assistant manager confirmed new staff completed an induction programme. This consisted of essential training and shadowing experienced staff members so they could get to know the people they would be supporting and working with. The assistant manager told us all new staff that had no previous experience in the caring profession also completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We looked at the staff training matrix and saw staff had either completed their mandatory training or it was planned. We saw staff had received training on mental health awareness, managing challenging behaviour and the MCA and DoLS and a course on low level intervention had been planned for the 28 November 2016.

The records we looked at showed arrangements were in place that helped to ensure people's health needs were met. We saw evidence staff had worked with various community based healthcare professionals and made sure people accessed other services in cases of emergency, or when their needs had changed. This included GPs, hospital consultants, community mental health nurses, social workers, chiropodists and dentists. We saw some people had been diagnosed with a chronic physical illness. In these cases we saw evidence of interaction with relevant health care professionals.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with indicated that they were happy living at the home and with the staff that supported them. One person said, "I have lived here a while and like it, the staff are OK and are there if you need them." Another person said, "I still get bored sometimes but I think things have improved there is more to do and staff seem more interested."

At the last inspection we found people were not always being treated with dignity and respect as a result of institutional and poor care practices. For example, we saw people's appearance suggested they were not being supported to maintain standards of cleanliness they should expect. We saw some people's clothing was ill-fitting, not well ironed and stained with food.

On this inspection we found more emphasis had been place on treating people with dignity and respect and staff encouraged people to take more pride in their appearance. For example, we saw one person had put a top on that was stained, we saw staff spoke with them discreetly and the person happily went with them to change. When we arrived at the home on the second day of inspection we saw staff were blow drying one person's hair and assisting another person to apply nail polish.

We observed positive interactions between people and staff and saw staff spent time with people, engaged them in conversations and responded appropriately to their requests for assistance.

We saw people looked clean, well dressed and well-groomed which had not been the case at the last inspection and people looked relaxed and comfortable with staff. We saw at lunch time people were asked if they wanted to wear clothes protection, were offered a choice of cold drinks with their meal and if appropriate were encouraged to eat with discretion and sensitivity.

People who liked their privacy and wished to spend time in their rooms were supported to do so. The staff we spoke with were clear about the actions they needed to take to ensure people's privacy when delivering personal care. They told us they had been disappointed by the last inspection report and had tried hard to look at the daily routines of the home and ensure they were based around people needs and were less task orientated. They told us they now spent more time talking with people and listening to how they wanted their care and support to be provided than they had done previously and the staff team were more focused on promoting people's independence and life style choices.

We observed staff knocking on people's doors and waiting before entering. We observed that staff were respectful when talking with people, calling them by their preferred names.

However, we found in a shared bedroom one person's underwear had been put in the other person's chest of drawers. We also found one item of clothing named for another person who did not occupy the room and other items of clothing not named. This was discussed with the deputy manager who acknowledged staff needed to pay more attention to detail.

We saw care planning was an inclusive element of the service with many people benefiting from a Care Programme Approach (CPA). The CPA is a way services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of complex needs. We saw the outcomes of CPA meeting were translated into written care plans. We saw some people had been appointed with independent mental capacity advocates (IMCA) at the time DoLS were authorised. We saw evidence IMCA's had been involved in care planning reviews.

Requires Improvement

Is the service responsive?

Our findings

The registered provider told us they were in the process starting to implement a new care planning system and had appointed an external consultant to work with the clinical lead nurse to assess people's current needs and complete the documentation. However, at the time of inspection the new care documentation was not in place and staff therefore could only refer to care records which were sometimes out of date or provided inaccurate information. We were therefore concerned with the increased use of agency nurses there was the potential for people to receive care and treatment that was not safe or appropriate to their needs.

For example, we looked at seven people's care records and found care plans and risk assessments were not always up to date and some care plans had monthly reviews recorded which pre-dated the date the plan was written.

In one person's records there was a care plan about constipation which was dated 15 August 2016 and had last been reviewed on 18 August 2016. The care plan was accompanied by monthly reviews dating back to April 2016 and the reviews recorded in July and August referred to continuing to support the person with 'stockings' daily. There was no reference to stockings in the care plan.

In a second person's records we saw a care plan which stated they should be encouraged to rinse their mouth after each meal and brush their teeth at least twice a day. We looked in the person's bedroom and found they did not have a toothbrush. We did not hear staff prompting the person to rinse their mouth when they had finished their lunch. We looked in the person's daily care records and did not see any record of staff prompting or supporting the person to rinse their mouth or brush their teeth. The records did show staff had tried to encourage the person to visit a dentist but they had refused.

In a third person's records there was a care plan about personal hygiene. The care plan stated that following a visit to the dentist the person should brush their teeth three times a day with toothpaste which had been prescribed for them. The plan stated staff should ensure they used the toothpaste every day, 'without fail'. The care plan had not been reviewed since 29 July 2016. We looked in the person's room and found there was no toothpaste there. We asked the nurse in charge about this, they told us the person had a tendency to throw things away but said there should be more toothpaste in the medicines room. However, when we checked the tooth paste was not in stock.

In a fourth person's record we saw a care plan dated 14 March 2016 which stated they needed to spend some time in the communal areas where they could participate in life in the home including activities and social stimulation. The nursing intervention section of the care plan showed that a staff member would be allocated to spend time with the person on a one to one basis any time after breakfast in the communal areas. The care plan had been evaluated on the 11 November 2016 and the nurse completing the evaluation report had written "Maintain care plan as is." However, the deputy manager told us the person had been on permanent bedrest for a number of weeks prior to the evaluation report being completed and therefore the care plan was not appropriate to the person's current needs. This clearly indicated to us that the care plan

reviews were being completed as a paper exercise rather than a review of the effectiveness of the care plans in supporting people to meet their personal needs.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the activities co-ordinator who told us they worked between 20 and 25 hours a week and prior to taking up the post had previously worked at the home as a support worker. They told us they worked flexible hours including evenings and weekends and encouraged people to participate in a range of activities both within the home and the local community. They told us they split their time between group and individual activities which ensured everyone had some input.

The people we spoke with told us they enjoyed joining in activities, there was now more for them to do and staff spent more time with them. One person said; "Things are getting better, we get to do more and some of us went on a trip to Blackpool illuminations which I really enjoyed."

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The policy also detailed the timescales within which the complaint would be dealt with. The assistant manager told us people continued to be encouraged to air their views and opinions of the service so that areas for improvement could be identified. No concerns were identified in relation to the management of complaints at the time of inspection.

Inadequate

Is the service well-led?

Our findings

The registered provider told us in July 2015 they were stepping down from the role of registered manager and were looking to appoint a Registered Mental Nurse (RMN) to become the registered manager. However, we found at the last inspection in May/June 2016 no manager had been appointed although there was evidence the registered provider had advertised the post. The clinical lead nurse had been appointed acting manager but had made it clear to the provider that they did not want the post on a permanent basis.

On this inspection we found the provider had employed a new manager but they had left the service on the 7 November 2016 after only a short time in post. We saw a senior care assistant had also recently been employed and they had been promoted to the post of deputy manager when the manager had left. The registered provider told us until a manager was appointed the deputy manager was managing the service on a day to day basis assisted by the assistant manager and clinical lead nurse. We spoke with the deputy manager who confirmed they were committed to improving the quality of the service people received and creating a more positive staff culture within the home.

The provider told us they now visited visit the home on a daily basis had also employed the services of two external consultants, one to develop the quality assurance monitoring systems in place and the second to implement a new comprehensive care planning system. However, on the second day of the inspection we were informed by the provider that one consultant had been unable to commit sufficient time to the home and therefore only one consultant was now assisting them and they would be implementing the new care planning system. We concluded the inconsistent management arrangements had meant sufficient improvements had not been made.

At the last inspection we found the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the governance of the service. We had found the internal audit and quality assurance systems were not robust and had failed to identify the shortfalls in the service we found during the inspection process. For example; we found medication was not always administered as prescribed and risk assessments and records relating to people's physical care and treatment did not always provide accurate and up to date information which might have resulted in them receiving inappropriate care and treatment.

On this inspection we saw the consultant employed by the service had implemented a bi-monthly audit tool to be completed by the manager and had carried out the first comprehensive audit of the service in September 2016. We saw amongst other things the audit had identified shortfalls in the medication system, individual people's risk assessments and care plans, weight records and the monthly evaluation reports completed by the nursing. We saw of the nineteen areas covered by the audit eighteen required action to be taken and the overall score for the audit was only 29.5%.

We saw a second audit had been completed by the registered provider and deputy manager on the 30 November 2016 and was provided after the inspection. This showed of the fifteen areas covered only one required action to be taken. We saw the overall score was over 92%. The deputy manager told us the audit

tool had been amended to make it more specific to the service and improvements had been made in all areas which had resulted in the higher overall score.

However, we found although the registered provider had started to implement a new quality assurance monitoring system there had been no significant improvement in the overall governance of the service. We again identified concerns relating to the medication system, individual people's risk assessments and care plans, weight records and the monthly evaluation reports completed by the nursing staff. We found the registered provider had not taken the required action to address the shortfalls in the service identified at the last inspection even though we had been very specific about the areas which required immediate improvement. We therefore could not be confident people received safe, effective and appropriate care and treatment.

We also found where improvements had been they were not sustained. For example, at the last inspection we saw all as necessary (PRN) medicines were supported by written protocols which described situations and presentations where PRN medicines could be given. However, on this inspection we found there were no protocols in place although the clinical lead nurse told us they had been there prior to the inspection. This meant we could not be sure PRN medicines were being administered as the prescriber intended them to be used.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the registered provider gathered the views and opinions of people who used the service and their relatives and how they used the information to improve the quality of the service. We saw both resident and staff meetings took place, which gave people an opportunity to air their views and opinions of the care and facilities provided.

In addition, the assistant manager told us as part of the quality assurance monitoring process the service sent out annual survey questionnaires to people who used the service, their relatives and friends, staff and other healthcare professionals to seek their views and opinions of the care and support they received. The assistant manager confirmed the information provided was collated and an action plan formulated to address any concerns or suggestions made. The last survey was carried out in March/April 2016 and the positive comments made by people about the service provided were included in the last inspection report.

We saw the registered provider had the current CQC rating for the service on display at the entrance to the home.