Equilibrium Healthcare Limited

Oakland House 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

Overall summary

Oakland House Nursing Home currently comprises of three units, Elm, Cedar and Willow which accommodates up to 38 people. Accommodation is provided over three floors and each unit comprises of a dining room/lounge area and kitchen and all bedrooms are single occupancy. People living at the home have access to a large communal garden area which also serves as the designated smoking area for people living at Oakland House.

The home was operating at full occupancy on the day of our visit.

The service provides accommodation for people who require nursing or personal care and have enduring mental health needs.

There is a deputy manager in overall charge of the home and a registered manager who works across different locations owned by the same provider. The manager is registered with the Care Quality Commission. A registered

Summary of findings

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

The service was last inspected in April 2014. All areas we assessed at that inspection were judged to be meeting the regulations at that time. This was an unannounced inspection carried out on the 3 November 2015.

We found the provider did not always adequately assess risks. This was in relation to people's mental health and well-being. People's care records did not contain sufficient information to guide staff on the care and support they required. We found no evidence to show that people and/or their relatives were involved or consulted about the development of their care plans.

We found the system for managing medicines was not as safe as it should have been. The provider did not ensure the proper and safe management of medicines.

Systems were in place to assess and monitor the quality of the service provided but they were not robust enough to identify the issues of concern we found during the inspection.

Systems were in place to safeguard people from abuse. Staff we spoke with were knowledgeable about the correct procedures to follow to ensure people were kept safe and the home followed the correct processes to ensure people were not unlawfully deprived of their liberty.

Some areas of the home were not well maintained and attention was needed in some bathroom and toilet areas.

A safe system of staff recruitment was in place. This helped to protect people from being cared for and supported by unsuitable staff.

On the day of inspection we saw the staff worked in cooperation with other health and social care professionals to help ensure that people received appropriate care and treatment.

Checks were made to the premises, servicing of equipment and fire safety. Staff told us there was enough equipment available to promote people's safety and independence.

Sufficient numbers of staff were employed to meet the physical needs of people living at Oakland House Nursing Home. The home was working to improve the training opportunities and continued professional development of the nurses.

During our visit we saw examples of staff treating people with respect and dignity. People living at the home and their visitors were complimentary about the staff and the care and support they received.

People were offered adequate food and drinks throughout the day ensuring their nutritional needs were met.

We recommended that the home reviewed their medicine policy to reflect best practice.

We recommended the home ensured people had a personal evacuation plan to keep them safe in the event of a fire.

We recommended the home ensured all staff received training in relation to The Mental Capacity Act 2005.

We recommended the home ensured audits were done in line with current best practice guidance.

We found breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 in relation to the lack person centred care and poor record keeping.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Suitable arrangements were not in place with regards to the management and administration of people's prescribed medicines and medicine required 'as and when'.

We found the provider did not always adequately assess, monitor and manage the risks to people to ensure their health and well-being was maintained.

Staff had safeguarding procedures to guide them and had received training on what action to take if they suspected abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Some staff told us and records showed that not all staff had received all the necessary training and support needed to carry out their role.

Staff worked in cooperation with other health and social care professionals to ensure that people received appropriate care and treatment.

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met.

Is the service caring?

Requires improvement

The service did not always demonstrate a caring approach because there was no evidence in care plans that the home promoted people's independence.

An accurate, complete and contemporaneous record of end of life care and treatment was in place to show this was provided in a dignified way.

Staff were seen to be polite and respectful towards people when offering assistance.

Staff spoken with knew people's individual preferences and personalities and we saw positive banter and humour used between staff and people using the service.

Is the service responsive?

Requires improvement

The service was not always responsive.

People and their relatives were not always involved or consulted with in relation to care planning. People's assessments and care records did not include clear information to guide staff about how they wished to be cared for.

We did not see activities being offered as part of people's daily routine and people told us they would like to do more throughout the day.

Summary of findings

People were able to spend their time as they wished and people's visitors were made welcome.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service had a manager who was registered with the Care Quality Commission (CQC).

We saw systems were in place to monitor and review the service but these did not identify the issues we found at inspection.

We saw action plans completed whenever improvements had been identified via internal quality checks and audits, however, these were not done consistently.

The registered manager had notified the CQC, as required by legislation, of any accidents or incidents which occurred at the home.

Oakland House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 November 2015 and was unannounced. The inspection team comprised of three adult social care inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a mental health practitioner and the expert by experience had experience in advocacy and mental health services.

During the inspection we visited each of the three units and spent time speaking with people who used the service, their visitors and staff. Throughout the day we spoke with nine people who used the service, two visiting family members, nine staff members including senior support staff and support staff, three nurses, the cook, the activities co-ordinator the deputy manager and the registered manager.

We looked at the environment and the standard of accommodation offered to people. During the mealtime period we dined with the people who used the service to help us better understand their experience. We also looked at five people's care records, five medication administration records (MAR), four staff recruitment files, the staff training records, as well as information about the management and conduct of the service.

We looked at rotas over a three month period to ascertain whether the correct number of staff were deployed to meet people's needs.

We contacted the local authority commissioning team to seek their views about the service. We also considered information we held about the service, such as notifications made to us. We had received information of concern from the Clinical Commissioning Group (CCG) about poor medicines management. We received positive feedback about the home from the local authority commissioning team.

Prior to the inspection the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. Comments included, “Yes I am safe here, I like it, staff know me.” And, “This is so much better than where I was before, I am safe here.”

During our inspection we looked at how medication administration records and information in care notes for people living in the home supported the safe handling of their medicines. People were assessed to determine their ability to self-medicate and we found one person was self-administering insulin under supervision. This demonstrated the provider was attempting to maximise this person's independence.

We looked at five people’s medicine administration record (MAR). We also reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and people had received the medication they had been prescribed. We found people's medicines were available at the home to be administered when they needed them.

We asked a registered nurse about the safe handling of medicines to ensure people received the correct medication at the correct time. Answers given demonstrated they had a good understanding of their responsibilities however this was not always being translated into safe practice.

For example, we observed two occasions where people were not being administered their medicines as directed by the prescriber. Some medicines are required to be given either before or after food. On these two occasions we witnessed medicines which should have been administered 30 to 60 minutes before food were given whilst the person ate their breakfast. This meant the effectiveness of the medicine may have been compromised. We spoke to the deputy manager who assured us they would seek guidance from their pharmacist and ensure correct administration occurred in future.

Medicines may only be administered to people in care homes without their knowledge (covertly) within current legal and good practice frameworks. These are designed to protect the person who is receiving the medicine and the staff involved in the administration. The home had in place a medicines policy which included guidance on covert medication. During our inspection we were informed one person received their medicines covertly. We saw written approval from a psychiatrist to administer covert medicines. However, discussion with the deputy manager confirmed there had been no pharmacy involvement in determining a safe and effective method of disguising the medicines in food. We also found no record of which medicines the psychiatrist wished to be administered covertly and no evidence of a review process. The manager assured us a review of the person’s need to continue receiving covert medication would be conducted as a matter of urgency and had arranged a review before we left that day.

We looked at the provider’s current guidance with regard to administering non-prescription and over-the-counter products (homely remedies). We saw each person had a record of which homely remedies could be administered and under what conditions. The administration of these medicines was with the written approval of the person’s GP.

We carried out a random sample of eight people’s medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

However, we saw a letter from a hospital clinician dated September 2015 in which a prescribing error had led to a person receiving a double dose of an antipsychotic medicine. We saw a repeat prescription for November 2015 of 100mg every four weeks. The MAR sheet generated by pharmacy stated the dose was 200mg every four weeks. This meant the doubling of dose which had occurred previously and was noted by the hospital clinician in September 2015 was likely to be repeated in November 2015. The deputy manager contacted the pharmacy who rectified their error; however the home’s checking system for the receipt of medicines was not robust enough and had not picked up the repeated double dose.

There were no ‘as needed’ (PRN) protocols available to give guidance on the frequency or circumstances when these medicines should be administered. Whilst a nurse we spoke with had a thorough understanding of people’s needs and could competently judge from people’s manner and behaviour if they were in pain or agitated, there was a

risk that new or agency staff could not deliver appropriate care as there was no PRN protocol to follow. The manager assured us a PRN protocol would be developed to reflect each person's individual needs.

We looked at MAR sheets and care records to ascertain the frequency of use of PRN medication to help people manage their symptoms. From discussions with nursing staff and by scrutinising the MAR sheets we were assured non-pharmacological interventions were the preferred method of supporting people. This meant PRN medication was not used routinely to manage people's behaviour.

We recommend the provider's medicines policy is reviewed to reflect the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes' guideline (March 2014) which defines good practice.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. Whilst no controlled medicines were in use we saw suitable storage facilities existed. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures.

We saw evidence of three-monthly audits of medicines administration records. Audits showed where errors had been found and recorded how the error was addressed.

We looked at three registered nurses' training records which showed they had received medicines administration refresher training within the last year.

Staff we spoke with confirmed they had attended adult safeguarding training. Support staff could demonstrate a good understanding of safeguarding issues and were able to give examples of how they would identify abuse. Staff knew how to make a safeguarding referral and gave us examples of when they had done so. They also knew the principles of whistleblowing and assured us they would whistle blow if necessary. An inspection of training records showed that staff had received training in the protection of adults. Staff spoken with confirmed they had completed the training and had a good understanding on how to keep people safe.

During this inspection we saw the home was generally clean and free from malodour but some areas of the home were in need of attention. We found a strong faecal smell emanating from a lidless clinical waste bin the in the bathroom. This room also contained a padded and wheeled bath chair which had holes in it making it impossible to clean hygienically. We found repairs had been identified in other bathrooms. For example in one of the bathrooms the toilet roll holder had a bit broken off with sharp edge, and there was a sign on wall with an arrow saying "snapped and broken".

However we could see there were comprehensive safety checks and audits being carried out to ensure people were protected from the risk of unsafe care and treatment. For example we saw appropriate checks were done in relation to fire alarms, fire extinguishers and emergency lighting. Fire drills had also been carried out and there was a business contingency plan in place to outline how people would be protected in the event of unplanned emergencies.

There was a cleaner present throughout the day of inspection and a team of laundry staff. We saw infection prevention and control policies and procedures were in place. Staff were seen wearing protective clothing such as disposable gloves and aprons when carrying out personal care duties. Hand-washing sinks with liquid soap and paper towels were in place in the bedrooms, bathrooms and toilets. This meant people were protected from the risk of infection and cross contamination when receiving personal care.

We looked at the documents that showed the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helps to ensure the safety and well-being of everybody living, working and visiting the home. We saw that adequate equipment and adaptations were available to promote people's safety, independence and comfort.

We looked at what systems were in place in the event of an emergency, for example a fire. We saw a record on each of the unit's to show that regular fire safety checks were completed. However personal emergency evacuation plans (PEEPS) were not in place to assist the emergency services to evacuate the building in the event of an emergency. We

Requires improvement

Is the service safe?

spoke with the deputy manager who explained most people would be able to evacuate safely and follow instruction but agreed to ensure a PEEP was introduced for each person as a matter of urgency.

We recommend the provider ensures people have personal evacuation procedures to keep them safe in the event of a fire.

Prior to this inspection we had received information of concern about the care and support people received and that sufficient staffing was not provided at core times of the day to meet people's needs.

The deputy manager gave us an example where staffing levels had been altered as it had been identified that additional support was needed. For example when people needed to attend the hospital, an additional night time support worker had been agreed to the staffing quota at the home. We examined staff rotas; spoke with people, visitors and staff about the staffing levels. Rotas confirmed what we had been told about staffing arrangements. We also found that there were days when staff were supernumerary (off rota) but could respond if needed to help offer support and assistance when required. We observed this on the day of inspection. A call bell was activated from one of the bathrooms which suggested somebody needed immediate assistance. The senior support, who was supernumerary that day, responded immediately to ensure the person was safe. We therefore found that there was enough staff to respond to the physical needs of the people who used the service in order to keep them safe.

We looked at four staff personnel files to check how the service recruited staff. We found that a safe system of recruitment was in place. The files contained the following; application forms that documented a full employment history, a medical questionnaire, a job description and two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Records showed that the registration of the nurses was checked regularly with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse. We also were made aware that the home had made referrals to the NMC when they suspected malpractice had occurred. This meant the home, as far as was practicable, made sure people were protected against receiving poor care or treatment from unsuitable staff.

Requires improvement

Is the service effective?

Our findings

We looked at the training records for all staff and found differences in the amount of training done by support staff and the nurses. The support staff had a rolling programme of training and a high percentage of staff were fully trained. Courses included moving and handling, fire safety, safeguarding people from abuse, Mental Capacity Act 2005 and deprivation of liberty safeguards. There was also a programme called 'team teach' being rolled out across the service. Team teach aims to enable staff to support people to manage their behaviour more effectively through positive intervention and support rather than through physical intervention or medicine. Staff spoke positively about this training and we saw in management audits that the amounts of incidents which had occurred through inappropriate interventions had reduced by 83%. This meant staff had the skills and knowledge to support people to manage their behaviour in an appropriate way.

Support staff confirmed they received supervision and had "access to lots of training" but this was not echoed by the nurses. Two nurses told us they would like more regular supervision and access to training to enable them to demonstrate their continued professional development (CPD). CPD is a requirement of the Nursing and Midwifery Council (NMC) for nurses to be able to maintain their registration and continue to practice. We saw the service was in the process of introducing a re-validation scheme to help support nurses with their CPD and acknowledged the nurses needed more support to ensure this happened.

During the inspection we looked at the skill mix of the staff and whether there was an appropriate level of staff with the correct knowledge and experience to support people effectively.

We observed the nursing staff were focussed on tasks such as administering medicine and completing the clinical care records whilst the support staff assisted people with personal care and to eat. We asked both the nurses and the support staff whether they felt this was an appropriate distribution of tasks. They told us they felt it wasn't and they would like to work more collaboratively together.

We saw, and were told, that there was some division between clinical and non-clinical staff which meant nurses were not able to spend time with people living at the home and support staff were not involved in planning care for people. Support staff told us they would like to be more involved in the care planning of the people they supported and nurses told us they would like to be more involved in the daily lives of the people living at the home. We spoke with the registered manager and deputy manager who agreed support staff could be more involved in care planning to support the nurses and the people who used the service.

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We looked at five people's care files and found that, when appropriate, people were assessed in line with DoLS as set out in the Mental Capacity Act 2005 (MCA). We were told two people using the service were subject to authorised DoLS. Care plans confirmed the authorisations were in place. In addition we saw a further 12 authorisations had been applied for. Furthermore, the deputy manager told us they were in the process of considering a further eight people who it was thought may be being deprived of their liberty. Discussion with the deputy manager about the MCA and DoLS demonstrated their good understanding of the law and how it needed to be applied in practice.

We reviewed the care records of people with an enduring mental illness who had previously been detained in hospital under Section 3 of the Mental Health Act 1983. We saw at the time of admission to the service one person had been discharged from hospital on a Community Treatment Order (CTO). CTO's were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged into a community setting whilst still being subject to mandatory conditions. Any breach of these conditions can lead to recall into hospital. We spoke with staff about the CTO and the specific conditions; staff demonstrated a good understanding of the person's needs and the part these conditions played in supporting the person to remain in a community setting.

We looked at how people were supported in meeting their nutritional needs. One the day of our inspection we arrived at 8.00am. We noted that breakfast was being served in the dining room on each floor. At the request of the people living at the home there was a 'breakfast club' twice a week. This was where people would sit together and have a full cooked breakfast. We saw this was happening on the day of the inspection and people were offered a choice of foods.

Requires improvement

Is the service effective?

We asked people for their views about the food served at the home. People told us they had plenty to drink and had a choice about when they wanted to eat. They told us, "The food here is excellent, I have never eaten so well," and "Yes we can have what we want, I like takeaways and order them in regularly." On each of the units we visited we found that people were provided with plenty of hot and cold drinks and snacks throughout the day.

We looked at the kitchen and food storage areas and saw good stocks of food were available. People told us that food was always available when they wanted it throughout the day. People had their own fridges in their rooms if they wanted them and had access to satellite kitchens where they could prepare their own meals if they wanted to. Some people shopped online and had groceries delivered to the home along with takeaways when they wanted them. We spoke with the cook who knew the people well and tried to ensure everybody was well catered for. Most of the food was home cooked which people told us they enjoyed.

We observed lunch being served. The meals looked nutritious and the portions were ample. Two care records we looked at showed people were gaining weight but were within a healthy range. There was a good atmosphere at mealtimes and we saw good humoured banter between staff and people who used the service. People had the choice of where they wanted to sit and if they didn't want what was being served they were offered an alternative.

Accommodation comprised of three identical units over three floors. Each unit was kept secure via an electronic keypad door. People who used the service had swipe cards which enabled them to enter and exit the building into a shared communal garden. All bedrooms were single occupancy, with several bath and shower rooms and separate toilets throughout. Corridors were sufficiently wide enough for people who used wheelchairs and aids such as walking frames, and handrails were provided to promote people's mobility and independence.

Requires improvement

Is the service caring?

Our findings

We spent time observing staff interactions with people who lived at the home in all parts of the service. We saw staff were respectful and understanding. We spoke with staff who had a good knowledge of people's support needs and preferences. We observed staff speaking to people in a respectful manner and offering people choices. For example at lunchtime we observed one person refusing their sandwiches and staff offered alternatives efficiently and with minimal fuss.

There was a good rapport between the people who lived at the home and the staff who supported them. We observed staff knocking on bedroom doors before entering which demonstrated they respected the dignity and privacy of people residing at the home. The staff we spoke with displayed a good understanding about how to treat people with privacy, dignity and respect. One member of staff said; "If we are talking to people about personal things then that should always be done in private".

Staff understood that people with mental health needs may make decisions which could be considered to be unwise by others; for example smoking, eating unhealthy foods and drinking excessively. We observed staff responding well to people who presented behaviour which could have escalated into a challenging situation. For example one person was asking for a cigarette every few minutes. Staff explained to them that they could have one at 11am, which was the time they had previously agreed with staff to have a cigarette. Staff diverted the person by suggesting they went to their room to have their hair done. The individual responded well and went to their room with the member of staff. We spoke to the person later on as they were coming out of their room and they asked, "Do you like my hair, and do you think I look nice?" This person clearly looked happy as a result of staff helping with their hair.

When we checked the positive handling plan for this person we could see the support staff had intervened in the correct way for this person. The positive handling plan outlines the causes of a person's anxiety, what behaviours may then occur and what happens if they go into crisis. It identifies common triggers and guides staff on the correct way to de-escalate a situation in order to support people in a positive way rather than through physical intervention or medication. This plan helped staff work with people by promoting and respecting their dignity and demonstrated good practice when supporting people with complex metal health needs.

We noted people were clean and tidy and dressed in clothes which were their own. There were people in wearing football kits who were able to tell us about the team they supported and ladies wearing make-up and accessories. This demonstrated that the home respected people's individuality and respected their choices.

Three people who used the service were supported by independent mental health advocacy (IMHA) services. Discussion with the deputy manager demonstrated they had a good understanding of the importance of the part the IMHA played in providing advocacy. However, some staff we spoke with did not understand the role of advocacy or its importance to people who are unable to advocate for themselves.

We recommend the home ensures all staff receive training in The Mental Capacity Act 2005 to ensure people who use the service are supported to access advocacy services if needed.

We saw the home was displaying the daisy dignity in care award. This award is given by Manchester City Council to care homes which can demonstrate a high level of commitment to providing dignity in care to the people they support.

We looked at the care file for one person who was cared for at Oakland House at the end of their life. We found there were holistic plans which supported the person to make decisions about pain management, visitors, preferred food and music options. The person was also asked about where they wanted to die and be buried. We found preferences were clearly documented so that staff could support the person in the manner that they wished. Staff we spoke with understood the importance of ensuring people who were at the end of their life were supported in a dignified manner and in accordance with their expressed preferences. This told us that the service tried to meet the needs of people using the service who were at the end of their lives.

Requires improvement

Is the service responsive?

Our findings

People who used the service had mixed views about whether the service was responsive. They told us, "We can't really go out because there are no staff," and, "We would like more activities but there isn't really anything I can think I want to do, I like the bingo though". Others told us, "Yes the staff respond well to me, I can complain about things and I think they listen," and, "The staff know I like football and make sure I can go when it is on."

On each of the units there was a satellite kitchen which we were told people could access to make themselves drinks and snacks if they wanted to and to learn independent living skills such as cooking. However we did not see evidence in three of the care files we looked at which identified if people had the ability to manage activities of daily living themselves, such as getting dressed, taking a shower or preparing their own meals.

Whilst speaking with staff we asked them about how they aimed to promote people's independence whilst they lived at the home. Staff told us they encouraged people to do as much as they could for themselves, for example making snacks and drinks. However we did not see independence being promoted in this way on the day of inspection. We observed one person going into the kitchen area saying they wanted to make a drink; staff diverted the person back to their seat and offered to make it for them.

We examined ten care plans and saw little evidence to show that people who used the service, or their relatives, had been involved in the development of their care plans. We found care plans did not contain information which was easily accessible to show how people should be supported and cared for. In each of the care plans we looked at we found information which was out of date, duplicated or incomplete. For example each person had a care plan which was numbered in relation to different aspects of care. These included personal hygiene, mental health, ulnerability, mobility, medication, challenging behaviour, allegations, activities and night time. In six files the information relating to mental health was duplicated throughout the file. Care plans for activities were not completed, for example, the last entry on one person's monthly planner was 29/06/2015, and the health action plans for each person was not fully completed. We also found some records were illegible which we brought to the attention of the deputy manager for immediate action.

We found the provider was in breach of Regulation 17 (2 c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because the care plans were not in good order and some of the entries were illegible. In all the care files we looked at there were inconsistencies or missing pieces of information. This meant people were at risk of not receiving the care and support they needed.

We looked at the service's statement of purpose. A statement of purpose is a document produced by the company which outlines to prospective service users what they can expect from the service. This outlined that, 'service users are involved wherever possible in the development of their individual care plan and have a named nurse to ensure and enhance the individual nature of their care.' We checked four care plans to see whether people had a named nurse and found in three of them they had not. In the other one we saw there were different nurses named on different care plans.

The statement of purpose outlined that the model of care used at the home was based on the 'care programme approach' (CPA). This model of care is used by mental health services to support people with enduring mental health needs. The CPA aim is to ensure the person receiving care is aware of the services available to them, has a named care co-ordinator, has regular reviews and is fully involved in decisions made about their care and treatment.

With the exception of the 'positive behaviour plan' (a document used by staff to support people through positive interventions) we found care plans were based on perceived problems and issues and not on the achievement of meaningful outcomes. Without such care plans in place it would be very difficult for a service to be responsive to people with complex needs. For example, in each care plan there was a risk assessment in place in relation to 'suicidal ideology' regardless of whether this was a risk to the person or not. We brought this to the attention of the registered manager who explained the company were keen to use a recognised model of care planning to support people with enduring mental health problems. We found this care planning format and process to be institutionalised in its approach, focusing on a person's diagnosis rather than them as an individual. It did not provide a process by which a person's individual needs and priorities would be identified and then supported.

We spoke to two people who used the service about activities they took part in. Both told us they would like to

Requires improvement

Is the service responsive?

go out more but there were not enough staff to go with them on a one to one basis. We did not see activities taking place on the day of the inspection and were unable to find any personalised activity care plans within people's care files. Staff we spoke with said they would like to do more things which, "were personal to them" with the people they supported but said there was not enough time to do anything other than support people with personal care and at mealtimes.

We found this to be a breach of Regulation 9 (1 a b c, 2 b c d f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people did not receive care which was person centred.

There was a complaints procedure in place. The procedure was clearly displayed in the reception area of the home. We also looked at the complaints which had been made against the home. We saw that there were details about what the complaint had been about and what action had been taken. There was also a copy of the response which was sent to the complainant.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who took responsibility for the overall management of the service. The registered manager also managed another care home owned by the same provider and so was supported in her role by the deputy manager. There was a vacancy for a clinical lead manager who would support the deputy Manager with the nursing provision within the home.

Feedback about the leadership at the home was mixed. Most of the staff spoken with told us they felt supported and were able to speak with the deputy manager who was based at the home full time. Some staff were not sure how often the registered manager visited the home but did not see them not being based there as a problem. Others said the managers didn't always listen and were not as supportive as they would like them to be.

People who used the service told us the registered manager had a drop in session where people were encouraged to come and see her. They said they could request to meet with the registered manager by filling in a form to request a time and day which was suitable. We saw these forms were available around the home for people to access if needed. We and we saw examples of these requests along with minuted outcomes for the people who had attended. People told us this was a good way of speaking with the registered manager and they felt listened to and valued.

We observed the deputy manager had a positive presence within the home and that the people who used the service related to him well. For example during a tour of the building on the morning of our inspection we noted the deputy manager acknowledging each person by name and some people responding in a similar way. One person responded with, "Morning uncle Derek". This humorous and positive banter was encouraged which promoted a relaxed and friendly atmosphere. Staff told us the deputy manager, "Understood people's personal care needs and was good at the clinical skills and training".

We saw opportunities were provided for people, their visitors and staff to comment on the service and share ideas. The registered and deputy manager strived to involve and inform people as much as possible in the running of the service. For example, we saw a number of surveys were sent to people who used the service and their families. These included a menu survey and a service user experience survey. We also saw the minutes of residents' meetings and family forum meetings. This meant the home strived to ensure people and their relatives were involved in decisions about the running of the home and were encouraged by the service to provide feedback.

The service also held culture and values group meetings. These meetings were introduced to challenge perceptions and preconceived ideas staff have about each other and as a way of trying to get staff to think more positively. This meant the home was committed to ensuring staff understood and respected each other as well as the people they supported. It also showed that promoting staff morale was important to the managers.

We saw a range of audits and management reports were being completed by the registered manager and the senior management team. These included health and safety audits and health and safety committee meeting minutes, joint operations meetings, accident and incident audits and falls audits. This meant the management team at the home maintained a good overview of risks to ensure people were kept safe.

However, we found the audits of care plans and medication, although done regularly, were not as robust as they should have been. For example on three care plan audits, we saw action which had been identified as needed one month was identified again as needed the next month. However, on three other care plan audits we saw action had been taken appropriately and in a timely manner. We also noted that some of the areas we had identified as needing improvement on the day of inspection had not been picked up via the audit system.

There were no action plans of what was being done to address any issues identified in any of the audits we looked at. We saw there was an environmental audit tool which was done bi monthly. This had identified on three consecutive audits that "floors were dirty and needed a deep clean" but again it was unclear what action had been taken.

We recommend the home ensures all corrective action needed as a result of audits undertaken is appropriately documented and recorded in line with current best practice guidance available from The Health and Safety Executive (HSE) England.

Requires improvement

Is the service well-led?

We saw audits were done regularly by members of the health and safety committee in relation to accidents, manual handling, clinical waste management, gas safety, control of substances hazardous to health (COSHH), first aid and wheelchairs. There were no measures in place in relation to pest control which had been an issue at the home that had resulted in action being taken by the Local Authority' environmental health team.

There was a system in place to monitor accidents, incidents and safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response. Additionally, there was a record of what the outcome was and any 'lessons learned' to help prevent future re-occurrences. For example, a new nurse had recently administered the wrong medicine because there were a number of people with the same name on one of the units. The nurse had reported the error immediately and completed a comprehensive report to enable the incident to be monitored. Following on from this, and with consent, photographs were introduced on MAR charts to avoid the mistake happening again. More support was offered to the staff team and this was followed up at supervision. This demonstrated how the home operated in an open and transparent manner, took responsibility for mistakes and ensured lessons were learned to avoid future incidents.

We found that when safeguarding concerns/alerts or significant incidents had occurred at the home, appropriate notifications were sent to the Care Quality Commission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not ensure that there was a clear assessment of the needs and preferences for care and treatment of the service users. The provider did not enable and support relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user**

This section is primarily information for the provider

Enforcement actions

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