Westmorland Healthcare Limited

Westmorland Court Nursing and Residential 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 4 and 6 July 2016. We last inspected Westmorland Court on 29 September 2015. At that inspection we found the service was not meeting all the regulations we looked at.

Following the inspection on 29 September 2015 we issued four requirement notices. These were in relation to the management of medicines and the procedures in use that did not reflect current national guidance for the safe management of medicines. Also the registered provider could not demonstrate that effective monitoring and communication systems were in operation to help identify and assess potential risks to people and their welfare. The registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness.

We also found that incidents that had occurred within the home that might affect people's safety had not been appropriately referred to the local authority safeguarding team or notified to CQC.

We found at the last inspection that the registered provider had also not always acted in accordance with the requirements of the Mental Capacity Act 2005 (MCA). Also care plan assessments had not always reflected a person-centred approach to managing people's care needs.

Following the inspection in September 2015 the registered provider wrote to us and sent us an action plan saying how and when they intended to make the improvements needed to meet the regulations.

At this inspection on 4 and 6 July 2016 there was a continuation of breaches of two regulations where requirement notices had been issued at the last inspection in September 2015. This was in respect of Regulation 17 (Good Governance) as the quality monitoring systems were still not being fully effective in identifying risks. It was also in respect of Regulation 12 (Safe care and treatment) because the registered provider had not protected people against the risks associated with the safe management of medication.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following this inspection 4 and 6 July we asked for further information from the registered provider and manager and to provide reassurances on the immediate actions they were taking in regard to a safeguarding concern and the safe handling of medicines. This was to prevent any repetition of the concerns we had found and to mitigate any risks associated with the medicines management. This information was provided and on the second day of our inspection we saw that appropriate action had been taken to mitigate the immediate risks to people.

During this inspection we found a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This shortfall was because people who used this service were not consistently having care or treatment that had been planned specifically for them.

We found during this comprehensive inspection that the home had made some improvements since the inspection in September 2015 in aspects of quality monitoring and had introduced an audit system. Improvements had been made to the care planning systems and an electronic care management system had been introduced to help consistency. The system was aimed at making care planning more person centred.

The registered provider now has procedures in place and staff were acting in accordance with the MCA. We found that consultation had taken place with people living at the home and relatives about the use of CCTV in communal areas. We saw that a private room had been made available for relatives if people wanted more privacy. Surveys and residents meetings were being used to get people's feedback about the services being provided. Actions had been taken in response to feedback received. Appropriate policies and procedures had been developed regarding the use of CCTV in the home.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. There was a new manager in post who had been appointed at the home following our last inspection in September 2015 but had not yet completed the process to register as manager with CQC.

Westmorland Court Nursing and Residential Home provides accommodation over three floors that are accessible by a passenger lift and bedrooms are for single occupancy. At the time of the inspection there were 36 people living at Westmorland Court.

We saw that the staff on duty approached people in a friendly and respectful way. People told us that the staff were "kind" and "caring".

Care plans we looked at contained a nutritional assessment and a regular check was being done on people's weight for changes. People told us the food in the home was "good" and that they had a choice of food and drinks.

The home had systems to check information when new staff were recruited and all staff had appropriate security checks before starting work. The staff we spoke with were aware of their responsibilities to protect people from harm or abuse and what action they should take should it ever occur.

There was a complaints procedure. People who lived at the home and relatives we asked were aware of it. All the staff we spoke with told us that they had regular meetings where they could discuss practice and concern. They confirmed they had formal supervision and said they felt they were supported in their work.

Training records indicated that care and nursing staff had received induction training and training relevant to their roles. Staff had also been able to attend training courses put on by a local hospice on supporting people at the end of life.

We saw that there had been some fluctuations in the permanent staffing levels in recent months. At present the manager was taking steps to try to maintain an adequate level of staff using agency staff and overtime. These would not feasible in the long term and can only be seen as a short term contingency and CQC will continue to monitor.

There were examples of poor practice around medication management in the home. This indicated that in

these areas staff may not have fully understood the training and information provided. We recommended that the registered provider found out more about evaluating training for staff, based on current best practice and in relation to making sure staff understand and applied the training.

At this inspection we found that improvements had been made to the use of quality monitoring systems but these had not been fully effective. This was especially evident in the monitoring of medication management. There was still a lack of management oversight in some areas of practice and in checking daily records completed by the staff.

We found that there were few opportunities for people to participate in activities they enjoyed and organised activities in the home. The new manager was already taking steps to address this. Some bedrooms we visited did not have comfortable easy chairs in for people to use to spend time in their bedrooms. We recommended advice be taken from suitably qualified people on the provision of suitable seating for people with different needs and preferences for use in their private rooms.

The service rating overall remains Requires Improvement. Although some breaches of the requirements of the regulations have been addressed some still remain. We need to be confident that the registered provider can demonstrate consistent and improved practice over time.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were still not always protected against the risks associated with the use and management of medicines.

The service was experiencing fluctuations in staffing levels that could affect care provision but had applied interim measures to try to mitigate the risks associated with staff shortages. This included the use of agency staff.

Staff had received training on safeguarding people from abuse and knew what action to take if they were concerned about a person's safety or wellbeing.

Is the service effective?

Requires Improvement

The service was not always effective.

A staff training and development plan was in place and staff received supervision on a regular basis. Attention needed to be given to evaluating training for staff in relation to making sure staff understand and can apply the training given.

People's rights were protected because the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were followed.

People had a choice of meals, drinks and snacks.

Some people living in the home did not have comfortable easy chairs in for people to use to allow them to spend time in their bedrooms.

Is the service caring?

Good

The service was caring.

We saw that staff in the home attended to care needs as promptly as they could.

We saw that the staff treated people in a polite and respectful

way and offered explanation and reassurance about what they were doing.

We saw that staff engaged positively with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and treatment plans had not always been designed specifically for their needs. People could be placed at risk of receiving care or treatment that did not meet their needs or preferences.

People were being referred to their own GP's as well as other health professionals and services for treatment and assessment as needed.

Information was displayed on how to make a complaint for people to use. There was a system in place to receive and handle any complaints raised.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements to the quality monitoring systems had been made but there were still areas where the registered provider was not monitoring service provision effectively and so not meeting all of the requirements of the regulations.

Accidents and incidents in the home were being recorded and notifications required by the regulations that have been submitted to the Care Quality Commission (CQC).

Systems were continuing to develop to make sure the registered provider
and manager consistently sought and acted upon feedback from people using the service and their families.

Westmorland Court Nursing and Residential 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 4 and 6 July 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a pharmacist inspector.

During the inspection we spoke with six people who lived there and two visiting relatives and a relative of a person who had received respite care who contacted CQC with their experiences. We spoke with people in communal areas and in private in their bedrooms. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We looked in detail at the care plans and records for seven people and tracked their care.

Some people living at Westmorland Court could not give us their views and opinions about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

We also spoke with a visiting district nurse and a visiting GP about the home and their experiences of working with them. We spoke with three members of the nursing staff, four care assistants and the domestic and laundry staff on duty and a kitchen assistant. We spoke with the new manager, the office manager, the area manager and an office assistant who also worked in the kitchen when needed.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living in the home. We observed medicines being handled and discussed medicines handling with staff. We looked

at medication and records for 22 of the 36 people living in the home on the day of our visit.

We looked at records that related to the maintenance of the premises, the management of the service and regarding how quality was being monitored within the home. We looked at the recruitment records for four new staff working in the home.

Before our inspection we reviewed the information we held about the service and we spoke with local commissioners of the services to get their feedback on service provision. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals made to the local authority, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Requires Improvement

Is the service safe?

Our findings

People who lived at Westmorland Court told us about living there. One person told us "I would say it's a good place to live" and another told us "It's quite good here I think, compared to a lot of places". People also told us "The staff are nice enough but very busy, they tell me they are short staffed". One person who used this service told us "They [staff] are good with me but always seem busy at the moment, there's never anyone about to take me back to my room so I stay here" [lounge]. They told us "I have my bell here [attached to clothing] so If I am in trouble I can ring, they do come for the bell".

A relative told us "I've found the staff to be friendly and helpful" and "I have never seen anything that did not look safe, staff seem to do their best for people". We were also told "[Relative] looks much better now and is much happier living here".

At the last inspection in September 2015, we found that medicines were not being handled safely and we told the provider they must take action to improve the safe handling of medicines. We looked at medication and medication records for 22 people on the first day of our visit. We saw that some improvements had been made to handle medicines safely but with limited effect.

We found that people could not always have the medicines they were prescribed because medicines were not obtained on time and they ran out. For example seven out of 22 people had run out of one or more of their medicines such as antidepressants, strong pain killers sleeping tablets and anticoagulants for between one and 10 days. This placed people's health at risk of harm.

Medicines were not being administered safely. We saw that 20 out of the 22 people whose records we looked at were prescribed medicines to be given "when required" or as a "variable dose". When medicines were prescribed with a choice of dose nurses had not recorded the exact dose given to each person. There was no information to guide staff when administering medicines to be given as needed. This information was missing for a variety of types of medicines including analgesics (pain killers), medication for anxiety, constipation and sleeping. If this information is missing, especially for people with dementia, medicines may not be given effectively or consistently and people's health would be placed at risk.

Some medication such as antibiotics and paracetamol must have specific time intervals between doses. The time that these medicines were given was not recorded so it was not possible for the nurses giving the next dose to know if they were administering it with an appropriate or safe time interval between doses.

Medicines were not always being administered in accordance with the manufacturers' directions regarding food. We saw that medicines which must be given before meals were given at the same time as medicines which need to be given with food. If medicines are given at the wrong times with regard to food they may not work properly and people will not receive the full benefit of their medication, which places their health at risk.

The records about medicines could not be relied on to demonstrate that people had received their

medication safely .There were a number of signature omissions in the records which meant it was not possible to tell if people had been given their medicines. The records about the amount of stock of people's medication in the home did not always show that medication was accounted for or had been given as prescribed. The records about the administration of medication were also inaccurate, some medication had been given but not signed for and other medication had been signed for but not given. On the day of the inspection visit we saw one person missed having two doses of their antibiotic because nurses had failed to make proper records on the new record sheets for July.

We found a concern during the medicines inspection about the safe handling of medicine for one person and we asked the manager to make a safeguarding referral as a result of our findings. The manager made the referral to the local authority safeguarding team on the day we raised it

We also looked at the records relating to the application of prescribed creams. We found the information recorded to guide staff as to which creams to apply where was still incomplete, so creams may not be applied correctly. Nursing staff still signed for administering creams even though they delegated the application of them to care workers. Creams and thickeners were not being stored safely in people's bedrooms. All prescribed items should be stored securely unless it has been assessed that it is safe to not lock them away.

The storage of medication was in two dedicated medication rooms both of which had secure cupboards for keeping unwanted medicines, however we saw than in one medication room unwanted medicines had been left on the floor in an open topped box. This is against national guidance and is unsafe as the medication could be misused by others.

The action plan received from the registered provider following the inspection in September 2015 indicated that the improvements required for medication management would be complete by the end of February 2016. At this inspection in July 2016 it was not completed.

We asked for further information from the registered provider following the first day of the inspection for them to provide reassurances on the immediate actions they were taking in regard to a safeguarding concern and to the safe handling of medicines. This was to prevent any repetition of the concerns we had found and to mitigate any risks associated with them. This information was provided and on the second day of our inspection we saw that appropriate action had been taken to mitigate the immediate risks regarding the management of medication.

This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication.

We looked at the staffing rotas for the previous four weeks and spoke to people living at the home and staff about staff levels. We found that some staff had left the home recently including two care staff and the chef. We looked at how staff were being deployed within the home with the staff vacancies. Two members of staff with catering experience and qualifications were helping in the kitchen until a replacement chef was in post. There was a cook and two kitchen assistants working in the kitchen and there was a laundry assistant on duty. There were also 'nutrition assistants' on duty during the morning and for lunch to give additional support to people with their meals and drinks. These roles were to help free staff from these kind of duties that might take them away from care.

The manager and office manager were on duty five days a week and an on call system was in place out of

working hours. There were two registered nurses on duty during the inspection and rotas showed one on duty at night. There was a senior carer on each day shift and at night with two care assistants and during the days we inspected seven care assistants. The registered provider used a tool to help assess staffing needs based on people's assessed dependency levels. This assessment had been reviewed the previous week and staffing was being maintained in line with that.

However, people living in the home, relatives and staff told us that there were times when the home had seemed short of staff recently. We were told that there were times when people had not received aspects of personal care until after lunch as staff were so busy. We saw that staff were being kept busy providing basic care to people. In the first floor lounge the kitchen assistant had to stay after breakfast and supervise people in the lounge as staff were busy elsewhere.

We could see from our observations in the home that people were receiving basic care in line with their physical needs, although not always promptly. However staff did not have time to spend with people in a social way or to give emotional support or engage in meaningful activities. Staff we spoke with told us the service had "seen a lot of change" but that staff were "pulling together and they knew recruitment was underway. One staff member told us "Some staff have left and it puts progress back" but they felt there was a good staff team.

The manager was well aware that staff were under additional pressure with some staff having left or about to and was actively recruiting for permanent staff locally and from abroad. The manager confirmed that agency staff had been used, as a short term interim measure, to cover vacant posts in care and in the kitchen and current staff told us they were doing extra hours to help. The manager confirmed that routine admissions were not being taken until the staff establishment was stable. The manager had already recruited an activities organiser to help improve the situation. At present the manager was taking reasonable steps to try to mitigate the risk from the staff situation. This would not feasible in the long term and can only be seen as a short term contingency and CQC will continue to monitor.

We looked at accident and incident records held in the home and found that accidents and incidents that affected people living in the home been now being reported to the appropriate agencies for action and notifying CQC. Training records indicated that care and nursing staff had
received training on safeguarding people at risk of abuse. The staff we spoke with were aware of the need to report any incidents to their manager or the nurse in charge for action to be taken. We noted from the sample of care records we looked at that risk assessments had been completed, including falls risk assessments, moving and handling, pressure area care and nutrition.

We looked at staff recruitment records of the newest staff working in the home to see that checks required by regulation to help keep people living in the home safe had been done. The checks being carried out helped to ensure staff working in the home were only employed if they were suitable to work in a care environment. We saw required Disclosure and Barring Service [DBS] checks had been done and references obtained from previous health and social care employers.

There were two domestic staff to keep the home clean. On the day of our visit the home was clean and tidy. Equipment, bathrooms and wheelchairs were clean and free from debris.

Requires Improvement

Is the service effective?

Our findings

A visitor to the home told us, "[relative] is much happier here, we are pleased with progress, putting on weight and eating properly" and "They looked care for, always neat and clean and get their medicines". The person referred to told us that "The food is usually good, I enjoy my meals". "The staff are fine, polite and kind enough and know what I need doing". The people we spoke to all said that they had enough to eat and drink. Feedback taken at the resident's meeting had been positive about the meals provided and issues raised about food temperatures had been acted upon

People who lived in the home and relatives told us that staff called the doctor when they needed them. We saw that the district nurse visited people receiving residential care to provide wound dare and lymphoedema care. [Lymphoedema is a chronic condition where excess fluid is retained in the tissues causing a painful swelling].

At the last inspection in September 2015 we had found that the registered provider had not acted in accordance with the requirements of the Mental Capacity Act 2005.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at care plans to see how consent was obtained from people and how decisions had been made around treatment choices. We looked at documents regarding 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. We noted that the information held by the service around who held Power of Attorney (PoA) for a person was now being recorded. We saw that mental capacity assessments had been used with people to assess their ability to make specific important decisions.

We looked at the staff training records and saw that new staff had done induction training when they started working at the home. We could see that basic training had been provided for staff on dementia awareness to help with understanding the condition and how they could support people living with dementia. The new manager had introduced new work books for all staff to use to support their training in line with the Care Certificate for care staff. The Care Certificate is a recognised qualification from the government backed

training organisation Skills for Care. It is the new minimum standards that should be covered as part of induction training of new care workers. Staff confirmed that they did have the opportunity for supervision and support with a senior member of staff.

Staff we spoke with told us that "Training has got better". We were told that the Regional Manager was doing more 'in house' training with staff. Nursing staff we spoke with told us they had access to training to develop professionally. They told us they had access to the courses provided by the Cumbria Learning and Improvement Collaborative (CLIC). This training was aimed at Registered Nurses and the CLIC Clinical Nursing Skills Programme had a collaborative approach to education and learning across different health care settings in Cumbria. The project aimed to build trust and promote communication across nursing teams by improving networks and developing further opportunities for learning to help promote best practice.

Staff had received training in medicines management with their supplying pharmacist. However some of the shortfalls in practice around medication management indicated that staff may not have not fully understood or retained the training information.

We recommended the registered provider finds out more about evaluating training for staff, based on current best practice, and in relation to making sure staff understand and can apply the training.

The sample of care records we looked at showed that people were assessed for malnourishment and a regular check was done on people's weight for changes. We saw that if someone found it difficult to eat or swallow that advice was sought from the GP or the speech and language therapist (SALT). Information from these other professionals on the management of fluid thickeners was not being clearly stated in care plans for all staff to follow. However there was information for staff on the use of thickening agents for people's fluids in the kitchen and information was recorded on records in people's bedrooms.

The bedrooms in the home were all being used for single occupation and varied in size. We saw that some signage had been around the premises to help people who were living with the dementia to be able to move about the home and orientate themselves more easily. Ten of the bedrooms we visited did not have comfortable easy chairs in for people to use to spend time in their bedrooms. This meant that people were not able to spend time in private in comfort if they wished to or see their visitors there.

We discussed with the new manager the need to consistently provide appropriate seating in people's private rooms to meet people's different needs, preferences and to allow them to have comfortable seating if they wanted to spend time in their rooms.

We recommended the registered provider takes advice from suitably qualified people on the provision of suitable seating for people with different needs and preferences for use in their private rooms.

Good

Is the service caring?

Our findings

We spoke with people who lived in the home about how staff supported them to live as they wanted. We were told by one person who lived there "The staff are my friends". Another person told us "I am pleased with it here". Another person told us "The care staff are nice, very kind, very caring".

We spoke with visitors about how their relatives were cared for at the home. A visiting relative told us their relative had, "Settled in well" and that, "The main thing is they are happy here". Another relative told us that, "I think this is a caring home and there is a nice homely atmosphere".

We observed that there were information boards and leaflet holders in the foyer of the home. These contained information for people who used the service and their visitors about, dementia, social care services, access to advocacy services and how to make a complaint. People told us that they could have visitors when it suited them and there was a private lounge without CCTV they could use if they wanted

The registered provider had installed CCTV cameras in communal areas of the home and at entrances. A privacy impact assessment had been carried out and people living in the home had been consulted about this having been done. The manager planned to monitor people's views on the CCTV using surveys and make sure they were still comfortable with this.

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported by staff and how they were spending their time during the day. We sat in the lounges with people who were living with dementia. We saw that people who could not easily tell us their views appeared to be relaxed with the staff that were supporting them. We did not observe any negative interactions between staff and people living there.

Our observations confirmed people's privacy and dignity were maintained. We saw that bedroom and bathroom doors were closed when any personal care was being given. We observed that staff knocked on people's bedroom doors to make sure they could come in and to let them know who it was knocking.

The staff that we spoke to knew about the people they supported. They demonstrated concern for people's wellbeing and to provide good care. Some people were being nursed in bed and we observed that they had their call bells to hand so they could call staff when they wanted them.

During our observations in communal areas of the home we saw that most staff took the time to speak with people and took up opportunities to pass the time of day with them even if they did not have a lot of time to spend with them. We saw staff ask people what they wanted to eat and how they could help them.

Care plans contained some general information about people's care preferences should their condition deteriorate about place of care and arrangements. The manager had recruited an experienced activities and training coordinator to join the team in the home. This role involved training staff on end of life care and dementia care. Part of the role was also to help implement the service's dementia and end of life strategies

to improve service provision in these areas.

The home was caring for people at the end of life. Health care professionals we spoke with did not have any concerns about that care. The nursing staff had received basic training on the use of equipment used for pain and symptom control called syringe drivers from the specialist palliative care nurse working in the community. Staff had also been able to attend training courses put on by a local hospice on supporting people at the end of life.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we received comments from the people who used the service about their daily lives in the home. We noted that the registered provider had a complaints process in place. This was available throughout the home on the notice boards. Relatives we spoke with said they knew how to raise a complaint and that this was also in the information given to people when they came to live there. One person who lived there told us, "Can't say I have been given cause to complain as yet". Another told us, "You can ask to see the manager if you want and they do sometimes come around and chat with us".

Relatives also told us that they knew how to make a complaint if they needed to. One said, "The nurses are happy to speak with us when we visit and seem very open to our questions and comments". During the inspection we saw the clinical lead nurse going through a review with a family and answering their questions and going over the person's care and support needs. They spent some time with the family to give them support and information

One person told us, "It's not too bad here but there is not much to do. Look around, everyone is asleep most of the day". A relative told us "There is very little going on for people at the moment from what I have seen".

Staff knew, and we saw, that the personal care planning system was being changed and new methods of planning and reviewing people's care needs were being introduced by the new manager. We saw that care plans and risk assessments were in place for needs such as mobility, skin care and nutrition. Checks were being put in place for staff to use to monitor care plans better. We saw that that people's choices and preferences had started to be discussed and included in plans.

However this was not a consistent approach and was clearly not yet fully embedded within the staff approaches to care planning and reviews. Whilst some needs had been updated as people's condition or needs altered some had not. Reviews were not consistently identifying this or that some people's needs required more detailed assessments. Important information was missing from the care plans of some people. For example, information on diets such as soft or purred or if a person was now taking nutrition orally was not present. Information was in place if people needed specific fortified drinks.

Some people had a thickener prescribed to ensure that they could have drinks and other fluids without choking. There was not clear information within the care plans about how each person's drink should be thickened. However there was information to refer to in the kitchen and on charts in people's rooms to help inform staff. People who were prescribed insulin had their blood sugars monitored but there was no information to tell nurses what the person's 'safe range' should be.

A number of people were prescribed medicines to be used to prevent pain and other unpleasant symptoms during their end of life care. Limited information was recorded in people's care plans to guide nurses as to when these drugs should be commenced in order to relieve unpleasant symptoms.

The registered manager acknowledged that not all of the care plans and assessments were up to date

reflections of people's needs and risks. We saw that work was in progress to address this matter since the last inspection but the progress in care planning was not consistent and there were areas where there were not clear instructions for staff. This work needed to continue and embed within the home's systems

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not consistently having care or treatment that had been planned specifically for them.

We observed during the inspection that there was no organised activities going on in the home or individual support being provided for one to one activities. We spent time in both communal lounges and made SOFI observations. We saw that people spent most of their time in the communal lounges.

We visited six people who were being nursed in bed and so could not join people in communal areas. These people did not have a plan in place to help promote their social interaction and individual interests to prevent their social isolation as they spent all their time in their bedrooms. No activities had been recorded as having been planned or done with these people. Some people had the radio on or the television in their rooms. Care plans we looked at did not evidence that emphasis was being placed upon finding out what people wanted to do with their time although the matter had been raised at a resident's meeting.

The new manager had reviewed the social and activities provision and had started to address the lack of organised activities provision at both an individual and group level. An experienced training and activities coordinator had been recruited and was due to take up their post in the home within the next week. They would work with people and families to find out and plan for specific needs and preferences and develop a range of activities people wanted. Part of their role was also to work with staff and management to develop a more dementia friendly and supportive environment for those people who were living with this condition.

We found evidence that people were being referred to their own GP's as well as other health professionals and services for treatment and assessment as needed.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the home made a range of comments about how the home was being well run for them. One person told us, "I see the manager about the place, usually if I go downstairs". Another person did not know that there were meetings held for people living there to attend and give their views. A relative told us "We don't have any issues with the management at present". One person whose relative had used the service told us they had been unhappy because "I could not get any reply when I rang the office and no one called me back".

At the last inspection in September 2015 we found that quality monitoring and audit systems were not being effective in monitoring the quality and effectiveness of the service and in identifying where improvements were needed. The monitoring and communication systems in place had not identified and assessed risks to people's welfare or consult effectively with them on the running of the home.

At this inspection we found that some improvements had been made to the use of quality monitoring systems but these had not been fully effective. This was especially evident in the monitoring of medication management. The registered provider was not making sure the audit system was effective identifying shortfalls and in following up on improvements.

The new manager acknowledged that the audits were not consistently identifying where systems were not being effective or needed changing. The regional manager was in the home during the second day of the inspection carrying out detailed audits on medication and care planning and looking at the relevance of the audit questions being asked by staff to make sure they were relevant.

Some audits had identified risks, such as the food hygiene audit had identified areas for improvement in food temperature monitoring. Also the need for some equipment for hand hygiene had been provided. These issues had been promptly addressed. Care plan audits had not addressed all potential risks or evaluated if all needs had been considered. The audit was being done on the electronic system and staff we spoke with were not always aware of what the system could do.

There was confusion about which policies and procedures staff should be following as updated policies were not in circulation for general use. New and update procedures were being held electronically and the old file was still being kept as back up and referred to. This had led to confusion over what procedure should be followed and inspectors were being given out of date policies to examine. The regional manager began to address this issue during the inspection.

A new system was already due to start during the month where all named nurses carried out their own audits and had responsibility for follow up. This was aimed at making sure all nursing staff made sure people's care plans were accurate and reflected what they wanted and needed. The timescales for making any necessary changes were lengthy and had not been checked by management to ensure they were being addressed during the long timescale for improvement. The changes being made needed to embed within the service so the systems become familiar to staff and so they could demonstrate the improvements being

made could be sustained.

There was still a lack of fully effective oversight in some areas of practice and of checking daily records completed by staff. This included records such as when continence pads had been changed and when people were being repositioned.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there were still shortfalls in the systems being used and risks were not being consistently identified and addressed.

The home did not have a registered manager in post as required by their registration with the Care Quality Commission (CQC). When we inspected a new manager had been recruited and had taken up their post in February 2016. The new manager had still to complete the process for registration with CQC.

At the last inspection in September 2015 we found that the registered provider had not ensured that CQC had been notified of incidents and accidents in the home that they were required to inform CQC of under the regulations. Following that inspection the system was improved and notifications were now made promptly to CQC regarding incidents within the home.

We spoke with relatives, nursing and medical professionals about communication in the home. We were told that staff were helpful and willing to assist them we were given examples of where communication within the home had not always been effective. For example when a request had been made by health care professionals to prepare a person in order to receive a treatment or test this had not been done on and the request had to be made three more times before it was done. Whilst the person received the treatment the poor communication systems had caused a delay and had wasted staff time.

We were told by a relative about calling the home and the telephone was not answered on the times they called. This meant that they had not been able to speak to people in charge and check arrangements. Those we spoke with felt that information was not always being passed on to the right people in the nursing and care staff and this had led to breakdowns in communication at times.

Steps were being taken to have a more open and inclusive approach within the home. We saw in the minutes of the residents meeting held in March 2016 that the new manager had asked that relatives might want to be more involved in the updating of the care plans. Families were invited to reviews where appropriate. We saw that this did take place as we observed a family taking part in the review process during the inspection. At the resident's meeting all agreed they wanted more communication from the home and wanted to be actively involved where appropriate with the care plans.

We recommended that the registered provider seeks information on appropriate systems and training for staff on consistently maintaining effective lines of communication within the service.

We found that resident's and relatives meetings were being held and items such as the use of CCTV had been discussed at these. These were held at three monthly periods. The minutes of the first meeting showed that the timing and content of the meetings had been decided with people and families at the first meeting. We found that surveys had been carried out to get people's views and the most recent had been on people's views of the food and on new menus. People's favourite foods were now being included in menu choices.

Staff were having regular meetings to share information and discuss practice matters. Staff we spoke with told us that there had been "A lot of changes" and "We are working to get things right". One member of staff

told us, "The new manager has had such a lot to do and we are gradually getting there". Staff we spoke with were supportive of the work being done and open to change and the development of the service for the people who lived there. A staff member told us "We might still be missing a few things but it can't all be done at once and we have been working on the care plans and risk assessments". Staff had also been adapting to and being trained in new systems such as the computerised care planning and assessment system. Staff told us they had needed to learn a lot of new things. We were told that the manager was supportive and that in addition to getting to work on action plans the manager had to get to know the staff as well. We were told "It's been hard on (manager), so much to do and so many changes to bring in".

In our discussion and feedback with the management team they had been open to the feedback from the inspection team. They had started to make changes whilst accepting that it could not be achieved quickly or without significant resources.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used this service were not consistently having care or treatment that had been planned and personalised specifically for them.