Donness Nursing Home Limited

Donness Nursing Home

Inspection report

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23 June 2016

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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

We carried out an unannounced comprehensive inspection on 2, 9 and 11 December 2015. 13 breaches of regulation were found and we served two warning notices, relating to staffing and good governance. The overall rating for this service was 'Inadequate' and the service was placed in 'Special measures'. The provider provided CQC with an improvement action plan to say what they would do to make improvements to the service.

During the inspection in December 2015, we shared our concerns about staff practice and staffing levels with the local authority safeguarding team, commissioners and clinical commissioning group. They reviewed and monitored people's care as part of a whole home safeguarding process. A further CQC inspection took place in March 2016. This was to check on the warning notice for staffing which we judged was not met as there were low staffing levels on some night shifts.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. This inspection on 14,15 and 23 June 2016 took place because the home was in 'Special Measures'. At this inspection, we found they were progressing with their improvement action plan and had met the majority of legal requirements.

However, there had been occasions when the registered manager had not notified us about issues that impacted on the running of the service. For example, changes linked to nursing arrangements within the home and when there had been problems with staffing levels on shifts. This meant the CQC was not being kept up to date with issues relating to risk. This also meant that this regulation had not been met since it was first reported on after an inspection in December 2015. We also found the warning notice served following the inspection in December 2015 had not been fully met. Records to ensure people received safe and good quality care needed further improvement. Quality assurance systems were not yet embedded as part of the regular quality assurance system because they had not been fully established and were not fully effective.

In the last six months, there had been significant changes in the home including the staff structure and the staff working at the home. The action plan had identified multiple areas for improvement and most of these had been addressed. We have made recommendations in relation to the design of the building for people living with dementia and the use of a nationally recognised staffing tool to assess staffing levels. We recommended improvements were made to ensure there was a consistent approach to induct new care staff following nationally recognised current induction standards.

Donness Nursing Home provides accommodation for up to 34 people who require personal care with nursing; 22 people were living at the home during our visit. The service provides care for older people, some people who are living with dementia. The bedrooms are on three floors, which can be accessed by two passenger lifts.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. The service is owned by a provider, who is a registered person. 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 Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. We discussed DoLS with the registered manager and looked at records. We found the provider was following legal requirements in the DoLS. At the time of the inspection, an application had been made to the local authority in relation people living at the service. This meant people's legal rights were protected.

Significant changes had been made to how staffing levels were managed. This meant there were sufficient staff on each shift, which helped keep people safe and their care and social needs met. Agency staff were used to fill staff vacancies with the same staff used where possible to be provide continuity for the people living at the home. Improvements were needed to ensure one staff member was fully supported and supervised.

Improvements had been made to recruitment practice to ensure all the necessary information was in place before staff started work at the home. Changes had been made to the management of staff training and staff were better supported to work in a safe and caring way. Systems had been introduced to monitor staff practice to ensure people were moved in a safe way and treated respectfully.

There were many examples of good care, with staff showing affection and compassion towards people. Staff practice had improved, which helped support people's dignity. Staff had good relationships with people who used the service and spoke about them in a caring and compassionate manner.

People were supported to see, when needed, community health care professionals. Care staff recognised changes to people's physical well-being and knew to share this information with nurses working in the home. Medicines were well managed and administered appropriately. People were supported to have enough food and drink, and people's weight and nutrition was monitored.

Steps were being made to create a regular activities programme to meet the needs of people in communal areas and those who chose to stay in their bedrooms. However, this was a new development and was not yet an established part of the care and support provided at the home.

After our December 2015 inspection, out of the five key questions the service had three requires improvement and two inadequate ratings. After this inspection, the service had received four requires improvement and one good rating across the key questions. Therefore, with this report, we have determined that the service is no longer in 'special measures'. We will inspect again within 12 months to determine further progress and improvement in the care of people who use Donness Nursing Home

There are breaches of regulation. You can see what action we told the provider to take at the end of this 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

Most aspects of the service were safe. However, there were areas for improvement regarding information for agency staff, the auditing of settings for pressure relieving mattresses, the reporting of faulty equipment and updating the medication policy.

Staffing levels were sufficient on each shift to help ensure people were safe and their care and social needs were met.

Staff recognised their responsibility to report safeguarding concerns in a timely manner.

Risks to people's health were monitored and equipment was in place to reduce risks to people.

The recruitment procedure was effective to help ensure new staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

Most aspects of the service were effective. However, there were areas for improvement regarding who was legally authorised to make decisions on people's behalf, recording how best interest decisions were made, inducting and supporting staff in a consistent manner and the design of the building.

The management of staff training had improved and systems were now in place to formally monitor their practice and development needs.

People's legal rights were protected as deprivation of liberty safeguard applications had been made.

People were supported to see, when needed, health care professionals..

People were supported to ensure that they had enough food and fluid to support their health needs.

Is the service caring?

Good

The service was caring.

Staff practice supported people's dignity. There were many examples of good care, with staff showing affection and compassion towards people.

Is the service responsive?

Requires Improvement

The service was responsive but there were areas that needed further improvement.

Steps were being taken to promote activities to motivate people and promote a positive well-being for people.

Care planning was in place to guide staff to meet people's individual care needs.

There had been no complaints and there was new information on how to make a complaint. The registered manager had worked with the safeguarding team and followed their advice in relation to a concern in relation to staff practice.

Is the service well-led?

Requires Improvement

Improvements had been made in the way the home was run. However, these systems were not yet embedded as part of the regular quality assurance system because they were not fully established and therefore not fully effective.

Some statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service.

Donness 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.

An unannounced inspection took place on 14, 15 and 23 June 2016. The inspection team consisted of two inspectors. We were accompanied by a specialist nursing 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.

Before the inspection, we reviewed the information we held about the service and the statutory notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care. We also reviewed previous inspection reports and information from health and social professionals visiting the service.

We met with most of the people living at the home. We spoke with nine people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so 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 living with dementia. We also spoke with a relative.

In addition, we spoke with ten members of staff, including agency staff, and the registered manager who is also the provider. We reviewed six people's care files, six staff recruitment files, staff duty rosters, 22 medication administration records, policies and staff training records. We also looked at records relating to the management of the service and observed staff sharing information about people's care needs at a shift handover. We spoke with community health and social care professionals as part of the whole home safeguarding process for their views.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in December 2015, there were four breaches of regulation relating to staffing levels, risk assessments for the building and for people, infection control and staff recruitment. We served a warning notice in relation to the deployment of staff. We completed another inspection at the home in March 2016 to follow up on the enforcement action we had taken. We found there were still low staffing levels on some night shifts and the warning notice had not been met.

At this inspection in June 2016, improvements had been made to staffing levels, infection control and staff recruitment. This meant the warning notice and regulations had now been met. However, we have made recommendations to help promote safe and consistent practice. The registered manager told us they would take further steps to address some areas where practice could be improved.

People benefitted from premises being maintained in a safe state, although two radiator covers were loose which the registered manager said they would address. Otherwise, the building and furnishings were well-maintained. Staff said the arrangements for any required maintenance worked well. They described a white board where items for repair could be recorded, or directly informed the maintenance person. However, an audit of wheelchairs showed that the last two checks found one wheelchair was missing a foot plate. This wheelchair was used during our visit and this posed a risk to the safety of the person using it. The provider confirmed that the fault had not been recorded on the white board and no action had been taken to address the fault. They will review how faults are recorded. The registered manager's service improvement plan had stated that staff had been reminded in February 2016 to report and remove defective equipment but this had not happened with one faulty wheelchair.

There were arrangements in place to ensure regular servicing took place, for example, gas and electrical servicing was on a regular, external professional contract. Where testing was needed to ensure a safe service, this was undertaken, for example, testing the water against the risk of Legionella infection.

Equipment was checked and serviced in accordance with the level of risk, for example, an oxygen concentrator, equipment to move people in a safe way and fire safety equipment. Staff described their training in the use of an evacuation chair should there be a fire, and most were clear how they should respond if the fire alarm sounded. Staff moved a person in a hoist using best practice and they understood why the method they used was safe.

The registered manager said they were using the updated fire evacuation plan to ensure people's personal evacuation plans were up to date. These documents are important. They ensure care staff and emergency services staff are aware of the safest way to move people quickly should they need to be evacuated in the event of a fire or other emergency. Records showed staff had received fire training which staff confirmed, although one new staff member was not able to describe their responsibilities in the event of a fire. The registered manager said this had been covered in their induction but they would address this topic again with the staff member.

Medicines were stored safely and securely. Stock levels tallied with written records, although records were untidy, which made them more difficult to audit. Staff checked medicines together against the records when they administered medicines, which needed a witness and a double signature, which was safe practice. However, the care staff witnessing the practice had not received specific training to complete this task. Following our feedback, the registered manager told us she had asked a staff member to organise suitable training from the local pharmacy for care staff to address this concern. The medication policy provided to us contained out of date information regarding a medication storage practice in the home and the outdated description of roles and responsibilities.

People received their medicines safely, on time and the correct amounts were given. Staff completed a medication administration record (MAR) to document all medicines taken so all doses were accounted for. Correct codes were used and these records were completed with additional information if people declined their medicines or people were given, as required, medicines. When people's medication had been stopped there was a record of the date this had happened. Photographs had been added to each person's medication file to help staff, including agency staff, identify people correctly.

People told us they felt safe at the home; one person said "I don't want to be anywhere else." People in their rooms had a call bell in reach. However, in one lounge the call bell had not been placed next to the only person sitting in the room. The person told us they would call for help and were confident staff would come; there were staff in areas near the lounge. The registered manager noted in their June 2016 monthly checklist that a printout of call bell response times showed staff responded promptly.

Following a previous out of hours inspection, which included visiting the home at night, we had judged people were not safe at night. On this inspection, a staff member told us how they ensured people were safe when they supported them at night. For example, ensuring their call bell was in reach, checking the bed rails were correctly positioned, checking people were warm and comfortable. We have received no further concern regarding staff practice at night and records connected to care at night had been completed by staff.

People's care records identified risks to people's safety and well-being. For example, some people's skin was at risk of pressure damage. We saw people identified as at risk were sitting on pressure relieving cushions. Staff ensured this cushion went with them when they were moved. Pressure relieving mattresses were used for people at risk of pressure damage; a spot check of five specialist mattresses showed one was on the incorrect setting for the person's weight. This potentially put the person at risk of pressure damage. Another mattress setting display was faulty and there was no log that this had been reported, although the mattress remained inflated.

The registered manager corrected the setting for one mattress and contacted the hire purchase company to address the fault for the other mattress. The registered manager said the expectation was for staff to visually check the settings. She explained the individual settings for each person should have been routinely recorded on people's pressure care charts, which were kept in people's rooms for staff to refer to. A staff member immediately went to update the pressure care charts to include this information once the error was identified. Safeguarding nurses have since confirmed that mattress settings have been accurate when they have visited the home.

People's risk assessments were up to date, and staff knew what the risks were for individuals, such as choking or self-harm. Changes had been made to help keep one person safe, who tried to use the stairs without staff support, which put them in danger of falling.

The registered manager said they shared the responsibility of organising shifts with the office manager. Staff told us staffing levels had remained stable since the last inspection; the same level as when the home was fully occupied. There were twelve vacant rooms. Several staff commented that the amount of staff sickness had reduced, which was reflected by the staff rotas. They said this was connected to staff being more reliable; one person felt the use of agency staff to cover care staff shifts had also helped reduce the pressure on care staff. Improved records were now kept of staff sickness and the steps taken to cover any shortfall.

The registered manager said staffing levels for the morning shift was one registered nurse and five care assistants, with one nurse and three care assistants from 2pm until 8pm. The provider's improvement action plan stated the proposed staffing levels should be four care staff in the afternoon. However, the number of people living at the home had reduced since this plan had been submitted to CQC.

We recommend staffing levels are reviewed using a recognised staffing assessment tool when people are admitted to the home again to ensure people's social and care needs are met.

There was an overlap of staff from the morning and afternoon shifts at lunchtime to ensure people were supported with their meals. Nursing staff and care staff were supported by hospitality staff, housekeeping staff and a cook. After 8pm, there was one registered nurse and two night care assistants. Rotas and conversations with the registered manager confirmed these levels.

Since the last inspection in March 2016, there had been significant changes amongst the nursing staff with five nurses either no longer working for the provider or not working as nurses in the home. One new registered nurse was recruited in March 2016, another registered nurse started in May 2016 and a further registered nurse was due to start in July 2016; leaving two nursing vacancies.

Registered nurses from local nursing agencies had been arranged to cover vacant nursing shifts and where possible the same nurses had been provided to promote continuity for people living at the home. Rotas showed three agency nurses had regularly worked at the home covering at least 54 shifts but 23 other nursing shifts were covered in a six week period by eight other agency nurses.

The registered manager had not implemented an effective system to help reduce the risks posed by the reliance on agency nursing staff who may not have worked at the home before. There was no specific agency nurse written induction list. Since May 2016, the induction for new nursing agency staff has mainly fallen to other agency staff to complete a verbal induction including a tour of the building and fire safety. This meant consistency could not be ensured as there was no written record of what staff had been told. There was a white board in the medication room with nursing information on it. However, one agency nurse said they had not been shown this as part of their orientation and during the inspection another agency nurse advised people's nursing needs written on the white board were out of date.

However, there was a core group of experienced care staff working at the home who provided stability and consistency for people living at the home. This group had worked alongside newly recruited care staff; three out of five recently recruited were already experienced in working in care. The registered manager told us there were currently no vacancies amongst the care staff.

Staff knew their responsibility to report abusive practice. They could recognise different types of abuse. They knew to report concerns in a timely manner and were clear about who they could speak with within the service to share concerns. Staff knew if necessary they could also contact external agencies, although some were unclear where the contact details for the local authority team that coordinates safeguarding concerns were kept in the home. The contact details were displayed in the office. The registered manager said they

had not received any new concerns relating to staff practice.

People were protected from unhygienic conditions. The standard of cleanliness at the home was high. Domestic staff worked seven days a week, which included laundry cover. Domestic staff explained how they arranged their work so that no area of the home was missed. Where deep cleaning was required this was factored in. They said, "Our routine is adjusted according to need".

Housekeeping staff had a thorough understanding of how to protect people from the spread of disease. For example, using a colour system for mopping different rooms, such as red for toilets. They confirmed they had protective equipment available to them, such as gloves and aprons, and these were seen in use. Housekeeping staff said they were very satisfied with the level of training they received, which included infection control and how to handle chemicals in a safe way.

There were hand washing facilities throughout the home for visitors and staff to use to promote hygiene. Hand gel was made available to visitors entering the home to help reduce cross infection. Care staff confirmed there were gloves and aprons for them to use and we saw staff wearing them. Discussions with care staff and training records showed infection control training had taken place. The registered manager reminded a care staff member about their infection control practice during the inspection showing poor practice was addressed.

There were effective recruitment and selection processes in place. The registered manager had improved their recruitment procedures to ensure new staff were suitable to work with vulnerable people. Recruitment files provided an improved audit trail of the steps taken to ensure new staff members' suitability, which included references and appropriate checks. Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Records showed the registered manager checked the registration of nurses being recruited to work at the home.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in December 2015, there were two breaches of regulation relating to protecting people's legal rights and ensuring staff were supported appropriately to carry out their roles. At this inspection improvements had been made and both of the regulations had been met. We have made recommendations to improve the design of some areas of the building. The registered manager has told us they were taking further steps to address areas where practice could be improved.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. Applications had been made appropriately so people's legal rights had been protected.

People were given choices about their care and treatment. For example, people were asked what they would like to eat, where they wanted to spend their time and staff gained people's consent before supporting them with care tasks and treatment. Staff told us that they needed to treat people's wishes with respect and minutes from a staff meeting showed discussion had taken place regarding promoting choice. Throughout the three days of our inspection, staff consistently checked with people that they had understood their wishes and provided simple options to enable people to be involved in their care. For example, what type of food they would like to eat. During one lunchtime period, one person was provided with three different meals to try and encourage them to eat; staff listened and responded to their requests.

Best interest decisions were not documented in a consistent manner, such as the use of bed rails to keep people safe and the use of motion sensors in some people's rooms. For example, records for one person showed a motion sensor was in place to enable staff to be alerted to provide them with assistance. There was no record if professionals or people significant to them had been consulted on the person's behalf to ensure this was in their best interest. The registered manager had recognised this was an area for improvement in their June 2016 audit of care plans and told us documentation needed to be improved. Another person who had previously had a motion sensor in place in their room, no longer had this arrangement because their care needs had changed. This showed the registered manager recognised the changes in people's care needs and made adjustments accordingly but recording did not show the decision-making process.

Documents did not always demonstrate people's legal responsibilities. For example, a person, who was judged not to have the capacity to be involved in complex decisions, had moved rooms. Their daily care

records showed they had benefited from the move, which staff confirmed. Their relative had been consulted about the move and had agreed it would be in their interest. However, there were not records to demonstrate the relative's legal role in decision-making. The registered manager said they would address this issue.

This is a breach of regulation 17 (2) (c) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 because there was not an accurate record of decisions taken in relation to care and treatment of people using the service.

The registered manager confirmed previous nursing staff had all completed basic life support training following a previous safeguarding concern. However, most were no longer working at the home; she advised she was due to arrange this training for a new nurse working at the home as a priority. She confirmed care staff were due to attend this course in September 2016.

New care staff were provided with an induction handbook from Skills for Care, which is a national organisation. The registered manager said they had not yet used the new Care Certificate which had been introduced in April 2015 as national training in best practice. Records showed that some new staff were working through the Skills for Care handbooks over a period of time with senior care staff. This contrasted with some previously completed inductions which took place in one day and therefore may not have been effective. There was not a consistent approach to induction as one new staff member's training had not been recorded in their handbook, although they had been in post for six weeks. The registered manager said this would be addressed by a change of senior staff to supervise them.

We raised concerns with the registered manager regarding the ability of one staff member to lead a shift in an emergency situation. Following this feedback, the registered manager judged the person's communication skills had improved within a week and decided they would lead shifts with experienced staff. However, on their second shift as a lead staff member with two other staff, they were working alongside a staff member who was new in post. The third staff member was experienced but not a senior and therefore had to provide support for two new staff members on this shift. On this occasion, there was not an effective system to support the staff member. Since the inspection and following feedback from the local safeguarding team, the registered manager has taken steps to provide additional support for this staff member.

This is a breach of Regulation 18 (2) (a) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014

An in-house checklist for induction included fire safety and emergencies. A member of staff also provided guidance to new staff on moving and handling assessments and procedures although they did not have a specific qualification to provide training in this area of expertise. The registered manager said staff would not be involved in moving and handling practice until they were trained by an external trainer.

The registered manager said new staff with care experience did not work as an additional member of the shift. For example, a staff member told us they had worked shadowing another staff member on their first two shifts. Rotas showed they were not an additional staff member on these shifts. They told us their past experience had helped prepare them for their new role. They confirmed their practice had been observed by either a nurse or senior care assistant through spot checks, although records for these checks started a month after their start date.

The registered manager said if new staff did not have care experience they would work as an additional staff

member but there was no set time as it depended on their confidence and skills. A new staff member had been supported by another permanent member of the nursing team. They had worked alongside another nurse for shifts in a period of four weeks. The registered manager explained this was because they needed support with their verbal communication skills. They explained how they had supported the staff member through role play and discussion, although the registered manager had not yet written all of the sessions up to demonstrate this support.

Following our last inspection in March 2016, we reported on concerns that a staff member had been working in the role of a health professional when they did not hold the appropriate registration. During this inspection, we saw the registered manager had checked the registration of a permanent staff member with the Nursing and Midwifery Council (NMC) to ensure the person the person's registration was still valid. This meant the registered manager now had a system to ensure nurses held a current registration with the NMC and were fit to practice.

Staff told us supervision arrangements had improved for staff as they were taking place regularly. This meant the registered manager now had a system to show how they judged the competency of this staff. The registered manager said their aim was for experienced staff to have supervision every 12 weeks and for less experienced staff every eight weeks. A spot check on three staff members' supervisions showed these timescale had been achieved. Supervisions were also supplemented by spot checks on staff practice, which were recorded.

The registered manager confirmed that shift handovers took place three times a day which included registered nurses (RNs) from nursing agencies. They provided us with written information regarding communication between staff in the home, this included 'Agency RN's are orientated by the nurse handing over and accompanied by a member of staff for medication rounds...' The registered manager and staff said there was a named photo in each person's care plan with a brief summary of their diagnosis and a photo on their medication administration record for quick reference for new staff. Staff confirmed handovers took place between shifts, which we saw during our inspection. The information about people's care needs provided them with updates on people's care needs. For example, staff knew that a food and fluid chart had been started for a person and that they had been prescribed medicine for an infection.

Staff also told us they were supported to undertake professional health and social care qualifications. For example, one staff member had requested to change shift patterns to enable them to participate in this type of qualification and the registered manager had arranged this. The registered manager said three staff were due to start a professional care qualification. Ten care staff out of 17 held a professional qualification in care.

The registered manager had created a new senior care role; staff in this role were clear about their responsibilities, which included ensuring staff practice was safe and caring. Each senior had recently been given a specific area of care to champion amongst the care staff team. Senior care staff were able to tell us their plans to instigate their area of specialism and how they were being supported with developing their skills, such as senior care staff meetings.

Since the last inspection, improvements had been made in co-ordinating training to ensure staff practice was regularly updated. A staff member said "I love my job." Staff told us a range of core training updates had taken place including moving people in a safe manner, infection control, safeguarding, and understanding of the Mental Capacity Act. This was confirmed by a record of training sessions and individual staff records. Minutes from a staff meeting in June 2016 stated sessions were well attended. Staff recognised the importance of keeping their training updated and the disciplinary consequences if they did not. During the inspection, staff practice showed they understood their training. For example, training included dementia

awareness and understanding the importance of hydration. We saw staff encouraging people living with dementia to drink. A health care professional visiting the home prior to our visit had highlighted drinks needed to be accessible to people and judged some people needed more prompting to help them enjoy a hot drink.

People said they liked the food, one saying, "Brilliant". People received a nutritious diet and their personal preferences were met. The menu offered one lunch option but we heard other options being suggested by catering staff with individuals. Some people requested a different option and this was provided. For example, one person had egg and chips instead of roast pork, which was on the menu. One person said, "Cook's good. You've only got to ask and you can have what you want."

There was a list of people's dislikes, which included chocolate cake and cauliflower. Staff knew people likes and dislikes when they were chatting with them. The cook knew who was assessed as needing a special diet, for example where there was a risk of choking. One person, at risk of choking, had been assessed by a community health care specialist. Care workers had followed their instructions. They described in detail the risk from choking and how to assist that person with food and fluids to prevent this happening. Staff also had a reference poster on display called 'Choking and your responsibilities'.

Meals and drinks were provided at regular intervals, for example, one person's records stated they were offered a drink at 11pm each night following assistance with personal care. People were offered 'seconds' of the lunch and nobody was kept waiting for their meal. Where a person left their meal, their care plan showed their eating was dependant on how tired they were and we saw their meal was saved for them to have when they were less tired. Records showed people had a nutritional risk assessment, nutritional care plan and their nutritional status was monitored and concerns were acted upon. We spot checked on people's weight and saw it was monitored regularly and was stable.

Feedback from two of the local GP surgeries was positive regarding the care and attitude of staff. They said they had no concerns about the service, although one recognised recruitment could be problematic. They confirmed they were called in a timely manner and staff followed their instructions. Staff recognised changes in people's health, for example during our inspection one person had been referred to the GP because of a suspected infection and had been prescribed medication by the GP to resolve the problem. Staff were monitoring their well-being. Records showed staff contacted community health professionals and also kept the safeguarding nurses updated on people's health needs. Safeguarding nurses had worked with staff to make improvements to monitoring people's health, including a person with diabetes.

The design of the building did not always support people's independence, especially those people living with dementia. Most bedroom doors now had people's names on them but had no other features to help people distinguish one room from another. Since our last inspection, staff had been reminded in a staff meeting to ensure areas were well lit as it was recorded several people living at the home switched the lights off in corridors leaving them gloomy. This concern was raised at a previous inspection. Some people living with dementia can have a visual impairment and poorly lit areas could inhibit their independence and impact on their perception of the area. We also discussed with the registered manager the design of some of the carpeting in the communal areas as it was highly patterned and could cause falls if people living with dementia tried to pick up the patterns, for example a flower design. The registered manager said they would consider changes to the design when the building was next refurbished.

We recommend the providers consult current guidance on the design of environments for people living with dementia.

Good

Is the service caring?

Our findings

At our last two inspections in December 2015 and March 2016, there was a breach of regulation relating to protecting people's dignity. At this inspection, improvements had been made and the regulation had been met.

People told us they were happy living at the home and were satisfied with the care they received. A visitor told us they were welcomed by staff when they visited. We saw visitors were greeted in a friendly manner by staff and the registered manager. Staff also greeted people in a warm manner. For example, staff welcomed people and checked how they were feeling and where they wanted to sit when they came into communal areas. Agency staff showed they knew the people they were caring for through their conversations with people and us. This showed they were provided with individual information about people and had worked a number of shifts at the home.

Staff were caring; people we spoke with confirmed this. People looked relaxed with staff. For example, staff helped a person to move and used equipment. They took their time to explain what they were doing and did not rush the person. This helped put the person at ease. Another person was anxious about falling when they were being moved; staff reassured them throughout the transfer.

Staff thought about the way they spoke to people. For example, one staff member spoke quite quickly to a person living at the home; they offered a number of options in quick succession. They were looking at the person and when they saw they looked unsure, the staff member apologised for going too fast and changed their approach to suit the person. The person then looked more at ease and the staff member ensured they felt included in the choices. One person told us staff in general spoke too quickly, but they appreciated staff tried to speak to them more slowly.

Staff spoke about people in a respectful and understanding manner. For example, they knew what could make two people anxious and recognised situations that might make them nervous or apprehensive. For example, one person was unable to verbalise their anxiety but staff recognised the changes to their behaviour and sought to reassure them. For example, ensuring they had a cuddly toy which they knew the person drew comfort from.

Staff knew people well; one person said there were "really nice staff and they know me" and a staff member described people living at the home as being "like family." A visitor said their relative "always looked well cared for." There had been no new admissions for over six months; staff said they had more time to spend with people, which they said benefited people's well-being. Their conversations with people showed they knew people's life histories, such as their past jobs. One staff member used this knowledge to help them understand how a person might react to a situation. Staff recognised the relationships that were important to people living at the home. For example, another staff member encouraging people to reminisce about bringing up their children whilst they gave the person a manicure. This put the person at ease.

Senior staff had chosen areas of care which they wished to specialise in. One staff member had chosen to

champion dignity within the home. They told us about questions they had produced for staff on how to promote dignity in the way they worked with people. They had also emailed an organisation to supply promotional material to raise the profile of championing dignity; they were enthusiastic about this new role. Another staff member described how they would provide personal care in a way in which people's dignity was respected. People looked well cared for. The registered manager provided people with haircuts if they wanted them but said she could also organise trips to a local hairdressers if this was people's preference.

The registered manager and staff confirmed there was nobody currently being supported with end of life care. In people's rooms there was leaflet to help people consider advance decisions for end of life care. The training records for 2016 did not include training specifically in this area of care, although people had been supported with this type of care at the home in the last six months. There was not a policy related to end of life care. This was highlighted to the registered manager because a policy would offer guidance to staff to ensure people received consistent care.

Requires Improvement

Is the service responsive?

Our findings

Following our last comprehensive inspection in December 2015, there were two breaches of regulation identified relating to the home's complaints system and a lack of suitable arrangements to ensure people's social and emotional needs were met. At this inspection, improvements had been made and the regulations had been met. The registered manager has told us they would take further steps to address some areas where practice could be improved.

At the last inspection, we identified improvements were needed to the management of complaints and how information was provided to people. The improvement action plan completed by the registered manager stated an identification board would be put in place by March 2016 to help people identify staff. The registered manager told us this action had not yet been completed but would be within the next four weeks.

The registered manager confirmed there had been no complaints since our last comprehensive inspection in December 2015. Information on how to make a complaint was displayed on a board in the hall; the registered manager said this information would also be placed in people's rooms. A visitor said they would contact the registered manager or the office manager if they had a concern. People living at the home said they would feel comfortable raising concerns; some would approach staff and others would speak to the registered manager. A log book had been introduced to record complaints, which had not been available on the last comprehensive inspection; the manager's monthly audit sheet had an action point to tell agency and new staff about this record.

One complaint was received by CQC and the local safeguarding team in February 2016, which was investigated by the local authority safeguarding team. The outcome included additional staff training being arranged and referrals to the Nursing and Midwifery Council regarding staff conduct. Following this action, there were changes within the staff team, including some staff choosing to leave.

A staff member had shared a concern with the registered manager about another staff member's attitude towards improving their practice. We discussed this concern with the registered manager who told us they had recognised this issue as part of the person's last supervision. Since the inspection, we have received information, which showed action had been taken to help resolve the concern, although there was further work to take place due to the timescale, for example spot checks on their practice.

Improvements were being made to increase activities to motivate people and promote a sense of positive well-being but time was needed to establish this culture and approach. Staff told us they had more time to spend with people, although records did not show what activities had taken place as a result of this extra time. The registered manager had noted in a monthly audit that some people had visited the beach and spent time outside on the home's decking area. Staff chatted with people as they supported people with care or provided a manicure. A visitor said in the past people had just been left in the lounges but this had changed and staff spent more time talking with them.

One staff member gave four people sitting in one of the lounges the option of looking at a book. A fifth person showed through their facial expressions they were enjoying colouring in designs and looked happy when staff praised their skill at this task. A staff member explained their reasoning for choosing each book based on people's interests. People actively sat and looked at the books, turning the pages and in one person's case commenting on what they saw. This person then became animated and discussed photos of a royal wedding with the person beside them. Previously, they had become agitated with one another when no staff were in the room but looking at the book together had a positive impact on their relationship. Staff providing drinks or discussing the meal option then used the books to instigate a conversation with people, which people responded positively to.

During our inspection, a new staff member started work as an activities co-coordinator; the registered manager had previously told us about their planned recruitment. The staff member confirmed their hours, which were five days a week, and their plans to develop an activities programme. As it was their first week in post, they explained they were getting to know people as individuals. They recognised the importance of engaging with people who chose to spend time in their rooms, as well as with people who enjoyed the company of others in communal areas. They were experienced in their role, had a range of ideas they said had been successful in their previous role and confirmed they had access to a budget specifically for activities. During their first week, they had hosted quizzes and met with people individually.

As part of the safeguarding process the registered manager had voluntarily agreed not to admit new people to the home; a suspension had also been placed on admitting new people by commissioners. Therefore since our last comprehensive inspection there had been no new admissions to the home. The registered manager and staff at the home had worked with health and social care professionals to improve the effectiveness of care records for people living at the home, including records on checking the well-being and comfort of people in their rooms. For example, people being cared for in bed.

Care plans were in place for each person and showed recent updates. Records showed people or their relatives were involved in reviews of their care, which was an action in the registered manager's improvement plan. Care plans included clear instructions for staff to follow. For example, how to move people safely if they needed this level of support, details of the different type of transfers people needed support with, equipment to be used and the number of staff needed. Health professionals had reviewed people as part of the safeguarding process and their guidance was included in care plans, such as people's nutritional and choking risks.

Staff observed changes in people's well-being and responded to them appropriately. For example, a staff member described how one person could become distressed, including the signs they would look for. We saw staff taking action to reassure this person and help them to move to a place where they felt less anxious. Discussion with an agency nurse, who had worked at the home for over six months, about the same person showed they knew person's preferences regarding how they took their medication. For example, knowing how they needed to approach them so as not to make them anxious. Discussions with nurses and checking care records showed nursing staff reported changes in people's physical health to GPs. For example, staff had noted a person's health had deteriorated and observations of their health were increased. The GP was then contacted resulting in medicines being prescribed to address an infection. A relative said staff had kept them updated and said staff were now more attentive, they said they had "no worries on that score now."

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection in December 2015, there were three breaches of regulation relating to notifying CQC and the lack of an effective system to monitor and assess the quality of the home. We also took enforcement action linked to poor quality assurance systems. At this inspection, improvements had been made and one of the regulations had been met. However, the warning notice had not been fully complied with as some of the systems to assess, monitor and improve the quality and safety of the services were not yet fully established or effective.

There had also been occasions when the registered manager had not notified us about issues that impacted on the running of the service despite being reminded to do so in a meeting with CQC in February 2016. For example, changes linked to nursing arrangements within the home and when there had been problems with staffing levels on shifts.

This was a breach of 18 of the Care Quality Commission (Registration) Regulations 2009 because CQC had not been notified of incidents within the service.

The registered manager has provided CQC with information about changes within the management of the home once it had been requested.

The registered manager did not have effective systems to assess, monitor and improve the quality and safety of the services. For example, there was not an effective system for staff to report faulty equipment which the registered manager could audit and take action on. The registered manager said staff visually checked the settings for specialist mattresses but she had not put in place an effective system of recording these checks. One person's setting was incorrect; potentially putting them at risk of skin damage and the equipment was faulty on another person's bed so the setting could not be checked. The management of records needed further improvements to ensure they were up to date. Another person's health needs relating to monitoring their diabetes and their risk of seizure had not been included in their care plan; the registered manager had not ensured the care plan was updated.

The registered manager had completed an audit of the building but had not completed a risk assessment for individual people's rooms and the outside space, which was used by people living at the home. They said they would address this.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective system to regularly monitor and assess quality of the service and the risks to people living at the home.

The registered manager had been working with the local authority quality improvement team to review paperwork. A monthly manager checklist started in late May 2016 was a work in progress as not all areas had been assessed and some assessed areas needed an action point. Observations recorded on the form were positive regarding people's 'general care' but when we checked people's individual care records, they

indicated one person's teeth had not been cleaned for six days. We looked at a person's review where they had requested more baths, we saw they were usually being offered a weekly bath but staff had not recorded if they had been offered an additional bath. We spot checked the records of personal care for one person and saw for two mornings out of five had not been completed by staff. This meant there was further work needed to create an effective audit of care records to demonstrate the level of care provided. The registered manager raised recording as a topic for staff at a subsequent team meeting; staff were reminded that records needed to be completed to evidence good care and good staff practice.

The registered manager told us they planned to make changes to key documents, such as the home's statement of purpose, which would be placed in people's rooms. They confirmed this action had been delayed as other improvements had been prioritised but was work in progress. We highlighted the medication policy needed to be updated; the registered manager said they were reviewing polices. For example, they had made changes to the complaints policy. They had also written new polices relating to resuscitation techniques and updated a policy on staff induction.

The registered manager told us they were taking steps to address some areas where practice could be improved. Since our last comprehensive inspection in December 2015, there had been significant changes within the management arrangements at the home. A visitor commented that the home "has improved significantly since December..." The provider, who was also the registered manager, currently does not work as a nurse. Initially, an agency nurse temporarily took on the role as clinical lead at the service. During our inspection, the registered manager confirmed they had appointed a permanent clinical lead for nursing practice.

We met the new clinical lead who was an existing member of staff and therefore knew the people living at the home. The registered manager assured us they would have shifts allocated to them to as a clinical lead rather than a nurse to allow them time to continue to improve practice and improve the care planning at the home.

We requested that the registered manager confirmed in writing the appointment of a new manager. They provided this information and confirmed the person was due to start in October 2016 following a notice period from their current job. In a meeting with staff in June 2016, the registered manager promoted a positive attitude towards the changes stating they 'were necessary and essential.'

Previously the registered manager had delegated a number of quality assurance roles to other staff but had not timetabled into the rota shifts time to undertake their own role as manager. The rotas for June 2016 did not show when the registered manager was in the home but staff said they saw her regularly and felt supported by her. People's positive reaction to the registered manager showed that she obviously knew people living at the home well.

Health and social care professionals had commented on the positive way relatives responded to the registered manager at a meeting in May 2016 held jointly with commissioners to discuss the changes at the home. A letter had also been sent to people's relatives by the registered manager about the changes in their role, to keep them informed. The registered manager had not formally gathered feedback from relatives and visitors since our last comprehensive inspection in December 2015. For example, through sending out a quality assurance survey. However, feedback forms have been left by the visitors' book for people to complete. We reported on three of these responses in our last inspection report; no further surveys had been completed. The registered manager told us they had been in contact with relatives as a result of the meeting in May 2016 or through phone contact. We saw a record of a phone call to a relative who said they had no concerns about the care.

Following the last comprehensive inspection, the registered manager had taken action to secure areas unsafe to people living at the home, such as the sluice and laundry room. They had improved the recording of staff sickness and the action taken, as well as the management of training and staff support, including staff supervisions and staff meetings. A new role of senior care worker had been established. These staff members were carrying out spot checks to monitor staff practice and ensure staff were working in a person centred way with the people living at the home.

Staff told us the last six months had been a time of change; some expressed unhappiness at the level of monitoring of the service during the on-going safeguarding process. However, one staff member recognised that staffing levels had improved because the care staff team were more reliable and there was less staff calling in sick. There was stability in the staff group who worked in catering, housekeeping and hospitality support. Another staff member described positive changes within the care staff team, including the creation of the role of seniors. New staff told us they felt well supported and said there was good team work. Minutes from a staff meeting said 'all staff stated the environment was good, team working well, friendly and settled.' A person working at the home said "I think the girls work hard and on the whole the care here is pretty damn good..."

Improvements have been made to the way staff were involved in the running of the home. Staff meetings had increased with an improvement in the recording of discussions and a log of which staff had attended. For example, a meeting was held to update staff about the changes to the management of the home. Minutes from the meeting recorded that future meetings would be held for staff and people living and visiting the home to meet the new manager when they started at the home. A new system of observations of staff practice covering different areas of care had been introduced. These had been recorded to help demonstrate staff had the skills to be working in care and a respectful approach to people. Supervisions and appraisals were occurring more regularly, but were not yet embedded and part of the routine of the home.

Due to the level of concern following the last two CQC inspections, there has been a whole home safeguarding process which meant everyone living at the home was reviewed by health and social professionals. They had also provided advice to ensure care records improved and nursing practice was up to date. Staff told us the temporary clinical lead had involved them in discussions around changes to the care records, and said they could make suggestions. However, some staff expressed frustration regarding the amount of changes to paperwork.

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 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of incidents within the service. Regulation 18 (Registration Regulations)

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 Improvements had been made in the way the home was run. However, these systems were not yet embedded as part of the regular quality assurance system because they were not fully established and therefore not fully effective. Some records relating to decision making were not accurate or up to date. Regulation 17 (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff must be appropriately supported and supervised to enable them to carry out their duties. Regulation 18 (2)(a)