Vishomil Limited

St Winifred's Nursing Home

Inspection report

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20 June 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

St Winifred's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides nursing and personal care for up to 38 older people some whom may be living with dementia. Accommodation is provided on two floors with lift access between floors. There are communal areas on the ground floor, including lounges and a separate dining room. There were 22 people in the home when we inspected.

This inspection took place on 18 and 20 June 2018 and was unannounced.

At our previous two inspections we rated the service as 'Inadequate' and in 'Special Measures'. At the last inspection on 30 October and 1 November 2017 we identified six regulatory breaches which related to staffing, safe care and treatment, premises and equipment, dignity and respect, person-centred care and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

The home does not have a registered manager. The previous registered manager left on 30 June 2017. The manager who was in post at the time of this inspection started at the service in February 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although we found some improvements had been made at this inspection, concerns remained in several areas. We found continued regulatory breaches in relation to safe care and treatment, person-centred care, dignity and respect and good governance. We also identified a new breach in relation to staff recruitment.

We noted continued improvements to the premises and equipment. The home was clean, well maintained and many areas had benefitted from redecoration and refurbishment. We found environmental checks and audits were robust and effective.

Accidents and incident recording had improved and a monthly analysis considered trends and themes and looked at any lessons learned. Staff had a good understanding of safeguarding and the reporting systems and we saw incidents were recorded and reported appropriately.

Staff training and supervision had improved and a new induction programme had been introduced. We found there were enough staff to meet people's needs although the rotas showed the staffing levels at times fell below the levels the manager had determined as safe. However, we found staff recruitment processes were not robust as thorough checks had not been completed for two recently recruited staff.

We found shortfalls in the care and treatment people received. Medicines management was not safe and people were not always receiving their medicines as prescribed. People's care needs were not always being met as changes in individual needs were not reflected in care records or communicated to staff in handovers. Risks to people were not always recognised, assessed or managed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's nutritional needs were met, although the completion and monitoring of food and fluid charts was poor. People had access to healthcare services and systems were in place to manage complaints.

People told us activities were limited which our observations confirmed. People and relatives told us staff were kind and caring. We saw some caring interactions but also practices which showed a lack of respect for people and compromised their dignity.

People, relatives and staff spoke positively about the new manager. We found the manager responded promptly to any issues we raised during the inspection and continued to send us information of actions they had taken following the inspection. However, we found governance systems were not effective as the provider had not identified or addressed the issues we found which were only dealt with when we brought them to the attention of the manager.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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

There were enough staff to meet people's needs although we found the staffing levels cited by the manager were not always maintained. Staff recruitment checks were not robust as thorough checks were not completed to ensure staff's suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were recognised, dealt with and reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received induction, training and supervision.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), although the recording of some processes needed to improve.

People's nutritional needs were met. People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff were friendly and caring and we saw this in some of our observations. However, we also found people were not always treated with respect and their dignity was not maintained.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not always planned and delivered in a way which met their needs.

Activities were provided however people told us these were limited.

People knew how to raise concerns and complaints were recorded and dealt with.

Is the service well-led?

Inadequate

The service was not well-led.

The new manager provided leadership and direction in the daily management of the service.

Some improvements had been made since the last inspection. However continued breaches of regulations were identified at this inspection.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

St Winifred's 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 checked 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 18 and 20 June 2018. Both days of the inspection were unannounced. On the first day three inspectors, a pharmacist inspector and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day two inspectors attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We did not ask the provider to complete a Provider Information Return (PIR) as this was provided before the last inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed how care and support was provided to people. We spoke with ten people who were using the service, six relatives, three nurses, one care staff, the cook and the manager.

We looked at six people's care records, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection we identified breaches in the areas of safe care and treatment, staffing and premises and equipment. These related to medicines, risk management and staffing levels. At this inspection we found a continued breach in relation to medicines and risk management under safe care and treatment. We found improvements had been made to the premises and equipment and the staffing levels.

At our last inspection we found medicines were not managed safely. At this inspection we found that despite some minor improvements, medicines were still not managed safely and people's health was at risk of harm. We looked at 15 people's medicines and related records in detail and found concerns in each case.

We found the systems in place to manage medicines when people came out of hospital were unsafe. One person had returned to the home from hospital with some new medicines, but nurses failed to administer the medicines because they were unaware they had been prescribed. This meant the person suffered from the symptoms the medicines were prescribed to relieve. They were also prescribed an antibiotic to be taken for five days after they came back to the home. Nurses only administered it for a day and a half and then recorded that the course was completed. We asked the nurses on duty why it had not been given for all five days, but they could not give us an explanation. The same person was also unable to have their prescribed doses of Paracetamol, because it had run out. Not being given medicines as prescribed placed the person at risk of developing a further infection and of being in pain for five days.

Some people were prescribed a thickening powder to be added to their drinks to help them swallow safely without choking. The nurses had no information with the medicines administration records sheets (MARs) to indicate that people were prescribed thickeners or how thick to make their fluids. This meant nurses maybe unaware that people needed their drinks thickening, which could put them at risk of choking. One person's prescription for thickener had changed and one of the nurses on duty was unaware of this because there was no robust system for communicating changes.

We looked at how people's drinks were thickened and found they were not always made to the correct consistency. For example, one person's drink was much thicker than it was meant to be. If drinks are not correctly thickened they may cause choking or not be drunk, placing the person at risk of dehydration.

We saw the ordering system for thickeners was unsafe as nurses told us that sometimes they ran out. On the day of inspection one person only had enough thickener left in the tin for approximately two drinks. Following the inspection the provider sent us information which showed more thickener had been requested for this person on the day of the inspection and was delivered later that day.

People were not always given their medicines as prescribed. We compared the stock of medicines in the home for some people with the MARs. We found for some medicines there was more stock than there should be, indicating that medicines had been signed for but had not been given. We also saw on one occasion more medication was signed for than had been received into the home, indicating that this person had not had proper pain relief over a number of days. The stock counts also showed two people were only given half

the dose of one of their medicines without any explanation being recorded. Nurses did not always follow the manufacturers' advice when giving medicines. One person was prescribed a medicine that should not be taken within two hours of other medication however we saw this medicine was regularly given at the same time as other medicines. Following the inspection the provider told us they had contacted the pharmacist to obtain further guidance about the times for this medicine to be given. Another person was given two tablets at breakfast time which should have been given half an hour before food.

We found the times of administration for regular doses of medicines such as Paracetamol, were not always recorded. This raised the potential risk that doses may be given too closely together putting people's health at risk."

People were prescribed medicines to be given "when required". We found the information recorded to guide nurses how to administer medicines prescribed in this way had minimal personalised information. There was also no guidance available when medicines were prescribed with a choice of dose. This meant people prescribed medicines in this way were at risk of not being given them safely or consistently.

The systems for recording how to apply creams and documenting when creams had been applied were not robust. There was limited information as to when and how often creams should be applied. This meant creams were not handled safely and consistently. For creams that nurses applied there was no information as to where they should be applied. There was no information kept with the MARs the nurses used, to record exactly what creams the care staff were applying. This meant nurses could not check that care staff were applying creams properly.

When there were a number of creams prescribed to be applied to the same area, there was no information recorded as to the order the creams should be applied. We also saw when there were different laxatives prescribed there was no information about when to use which laxative. If this information is missing people may not be given the most effective doses of their medicines.

The records did not always show medicines had been given as prescribed. There were gaps on the MARs where it was unclear if the medicine had been given or not, or why it had not been given. Most of the MARs we reviewed had a photograph of the person to aid identification when administering medicines. However, two people who had been admitted in June 2018 did not have photographs in place. The records about the application and removal of medication applied in patch form were poor and could not always show the patch had been rotated between sites to ensure that people's skin was not irritated.

The storage of medicines was not always safe. We saw creams and thickeners were stored in people's rooms without a risk assessment in place to show it was safe to do so. The service had facilities to securely store waste medication. However, we saw waste medication was not being locked away and stored in line with current guidance.

The temperature in one of the medicines rooms was very high. Medicines must be stored below 25C and we saw the recorded temperatures showed it had been stored at over 30C on one day. There was no indication that any action had been taken to make sure the medicines were stored at a safe temperature. As at the last inspection there was no record of the maximum and minimum fridge temperatures so it was not possible to tell if medicines stored in the fridge had always been kept at the correct temperatures. We also saw the tablet crushers in use were dirty and had residue of tablets left in them. This meant they had not been washed between uses.

We found risks to people were not always well managed. Although we saw detailed risk assessments in

place for some people whose care records we reviewed, we found this was not always the case. One person who had been admitted to the home for respite care had complex health care needs. Although there were risk assessments in place for the use of bed rails, hydration and pressure ulcers; there were no risk assessments for nutrition, falls, choking and moving and handling which were fundamental aspects of this person's care. We found identified risks were not always acted on in a timely way. For example, one person's care records reported on 11 June 2018 that the person was very unsafe using the stand aid hoist as they were slipping through the sling belt. No action had been taken in response to this risk, and staff were continuing to use this equipment. We brought this to the manager's attention on the first day of the inspection and they took action to address this risk. Some information was not included in risk assessments. For example, one person's assessment for the risk of pressure ulcers dated 29 May 2018 did not reflect the fact that the person had a pressure ulcer. In another person's mobility and falls care plan we saw guidance which stated serial numbers of equipment used to assist the person, for example 'green transfer belt', should be recorded, however this was not completed. People should have unique belts for such assistance, to minimise the risks of poor handling, injury and transfer of infection. In the same care plan we saw moving and handling support increased the risk of the person becoming distressed and non-cooperative. The care plan stated 'Risk assessment completed and referral made to a moving and handling specialist,' however we could not find any evidence of this or any advice that may have been forthcoming from the referral. We concluded people were not receiving safe care and treatment in relation to the management of risks and medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff recruitment procedures were not always robust. We looked at the recruitment files for two staff recruited since the last inspection. All the appropriate checks had been completed for one of these staff. Although we found the employment history had not been checked thoroughly as a reference had been obtained from a person who did not appear as a previous employer on the person's application form or any other documentation. Similarly with the second staff member their employment history was not clear and references had not been requested by the provider. The provider had accepted an email from the employee, who had typed up their own references from a past employer and principal, as satisfactorily providing two references. The administrator told us the team leader had spoken to the referees; however there was nothing recorded within the staff file to confirm this. Following the inspection the manager applied directly for references for this staff member and sent us evidence of this. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incident reports were well completed and showed what action had been taken in response. The manager audited the reports monthly and the analysis was detailed, considering themes and trends and looking at lessons learned.

Staff we spoke with understood how to report safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the manager who they were confident would deal with any issues promptly and appropriately. Staff were also aware they could report concerns to other relevant agencies. Records of safeguarding incidents were well completed, showing the action that had been taken in response. Appropriate referrals had been made to the local authority safeguarding team and notified to CQC.

There had been improvements made to the environment of the home, for example new radiators with cool-to-touch surfaces had been fitted, new carpets and hard floors were in place and new beds with integral bedrails had been purchased for people. We spoke with the maintenance person who told us they received clear information about works that were needed, and we saw the file used to store information about required repairs and their completion also had a timetable showing key responsibilities and when these

should be actioned, for example environmental checks and tests including those for emergency systems.

We found people lived in a clean environment. We spoke with a member of domestic staff who told us they worked to a defined schedule to ensure all areas were cleaned regularly. They told us this system worked, and showed us checklists in each room which enabled them to see 'at a glance' which tasks had been completed and those which were still outstanding. They told us they felt there were enough cleaning staff deployed at the right times to enable them to keep the home clean, and said night staff also assisted with this. Systems were in place to ensure infection control practices were followed. We observed staff wore personal protective equipment such as gloves and aprons appropriately. Facilities were available to ensure good hand hygiene, including hand sanitiser.

People and relatives told us they felt people were safe in the home. We asked them if they felt there were enough staff and received the following comments; "I think so yes, they are in different places at different times. (Family member) used to have to wait for help but not so much now, it depends on what they're doing"; "I suppose so…I have a red button (to call for help). Sometimes it is not so long (before they come), sometimes a bit longer" and "Sometimes you can wait for ages (for help). You can have a bit of a wait at night."

Staff we spoke with mostly felt there were enough staff, although one staff member said, "We need more. For example, we have so many people who need assisting with their meals, if we all went to one person each at the same time there would be no one left on the floor."

We observed there were staff available to people during the inspection. Staff told us they monitored the communal areas and we saw this happened in practice.

The manager told us staffing levels were calculated according to people's dependencies. The manager was intending to add the additional factors of layout of the building and staff ratio to the dependency tool. The overall dependence tool categorised people into low, medium and high dependency. However, there was nothing to show how this equated to the number of staff required. The manager stated they knew this was the correct level because there were working routines in place for staff. This meant the manager had observed people's needs and the layout of the building. It took them a month of observations and getting to know people to develop working routines. They determined what staffing levels were appropriate. The manager advised they were recruiting to staff vacancies for nurses, care staff and a domestic. Existing staff and agency staff were being used to cover the shortfalls. The manager advised regular agency staff were used to ensure consistency.

The manager told us the usual staffing levels were two nurses and five care staff from 8am until 2pm, and Monday to Friday there was an additional care assistant who also worked as an activity organiser. Form 2pm until 8pm there was one nurse and five care staff. There was one nurse and three care staff on the night shift. We looked at the duty rotas for the three weeks leading up to the inspection and found these levels were not always maintained.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we identified a breach in relation to staff training. At this inspection we found some improvements had been made, although further development was required.

The manager had developed a new three month induction programme for care assistants that also formed a competency assessment. One recently employed staff member, who had no previous experience in care, had started the new induction plan on 7 May 2018. However, the vast majority of it had not been completed. They had completed a short section on nutrition and fluid care. They had not completed safeguarding, first aid, moving and handling, fire safety or consent training. The staff member was booked to attend safeguarding, dementia, health and safety, equality and diversity training in June to the beginning of September 2018. They were scheduled to attend MCA training on 6 June 2018. We spoke with the staff member who said they had forgot to attend as they were on shift. We checked the rota and this person was on the rota to work 8am to 2pm so they could not have attended this training.

A training matrix was in place, which showed staff training was up-to-date. We randomly sampled four staff training records to see if the information was correct. We asked to see training certificates to confirm the information on the training matrix was correct, however, these were not provided. Following the inspection the provider sent us certificates for two of these staff. A training bulletin was on display in the office confirming when training was booked, and we saw training and other support was discussed during supervision meetings.

We spoke with the manager about staff competencies. They said they completed a walk-around, and if any issues were identified this was discussed in supervision meetings. If staff saw practice they had concerns about or if the manager felt there were issues, they would fill out a 'corrective action form'. If necessary disciplinary action would be taken or group supervision held. There was only one form relating to staff in the 'corrective action' file. This was in relation to poor coordination of staff on duty, and a resident not getting breakfast until lunch. In response working routines had been amended. The new induction programme incorporated a competency assessment, however, the manager told us the only other formal competency assessments in place were for medication.

A supervision matrix had been formulated for the year. Staff were scheduled to have four supervisions and one appraisal. We randomly sampled supervision and appraisal records which confirmed the matrix was accurate. We saw records which showed group supervisions and supervision training sessions were also held. For example, in relation to manual handling and medicines administration. Only one person had signed a supervision agreement. The manager told us this was work in progress.

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 authorisation 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.

The manager had a matrix which showed the date a DoLS application had been made, who had a DoLS authorisation in place, the expiry date and details of any conditions. We saw four people had conditions on their DoLS authorisations, we checked two of these and found the conditions were being met.

We saw care plans contained assessments of people's capacity to make specific decisions, such as to have bedrails or sensor mats in place. In one care plan we saw an assessment related to covert medicines was accompanied with a best interest decision that showed who had been involved in making the decision. In another, however, we saw the decision to reside at St Winifred's had only involved members of staff. Capacity assessments for another person showed they lacked capacity in relation to using a hoist and being supported with healthcare, yet there were no best interest decisions recorded.

We found the recording of people's consent to their care and treatment was variable. For one person we found no record of consent in their care file. In another care plan it was not clear whether the person had given consent for professionals to access their care records, as they had signed one part which said they had consented and another which said they withheld their consent.

Most people told us they liked the food. Comments included; "I have a choice. Breakfast there's porridge, toast, also eggs, bacon. There's a choice of tea, coffee, hot chocolate. You get breakfast, snacks, lunch, snack, tea. It is quite good food, a good lovely choice" and "You can have your breakfast in your room if you like but I like it here (in the dining room). I chose my dinner this morning, there is a choice of two meals." One person said they did not like the food.

We spoke with the cook who had a good knowledge and understanding of people's dietary needs. Menus were devised on a four weekly rota with a choice at each mealtime. The cook told us all meals were homemade, including cakes and puddings. A list was displayed in the kitchen showing any particular dietary requirements such as people who were diabetic or needed a pureed diet. The cook told us all meals were fortified with full fat milk, cream and butter to provide additional calories. The kitchen had been inspected by the Environmental Health in January 2018 and had achieved a five star rating (the highest rating which can be awarded).

We observed lunch in the dining room on the first day of the inspection. The lunch menu was displayed on a blackboard. We saw tables were laid with a small floral arrangement, cloths, napkins, cutlery and condiments. There was a wait of 30 minutes between people being seated for lunch and the meal being served. People were offered a choice of drinks. Meals were served ready plated and people were asked if they would like their food cutting up. We saw where people required assistance from staff this was provided.

Care records indicated appropriate referrals to healthcare professionals such as the GP, speech and language therapists, district nurses and the community matron had been made.

We found there was only minimal dementia-friendly adaptation to the premises. We saw pictorial signage added to doors, for example to indicate toilets, dining room and kitchen. There was little directional signage to assist independently mobile people with orientation, for example to show which direction they should walk in to find the dining room, lounge or bathrooms. Some people's bedroom doors had a picture of the person and their name. The main form of stimulus in lounges was television, although music was playing in

the dining room during meals.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we identified a breach in regulation as we found people's dignity was not always respected. At this inspection although we found staff were kind and caring, we also observed instances where people were not treated with respect. Our evidence shows a continued breach in regulation.

The majority of people we spoke said they liked the staff and thought they did a good job. One person when asked about the staff said, "They're alright yes, some you care for more than others." Another person told us they were happy living in the home. A further person said, "I am happy here. I have a room on my own, it is nice." One person told us, "I'm not happy now, it's not like it was. There are too many agency staff, most are alright, people keep coming in and I can't remember their names." This person expressed dissatisfaction with many aspects of their care, and the manager agreed to speak with the person to try to resolve their concerns.

Relatives also praised the staff. Comments included; "It's very good here. Staff here always listen and act no matter who they are"; "I have no complaints. They look after her very well" and "(Family member) is well cared for. Staff are great and always offer a cup of tea."

We observed some kind and caring interactions between staff and people who were living in the home. For example, we saw one person was clearly enjoying chatting about their relative with staff. We saw staff knew the person well and understood how to engage them in remembering things the person and their relative used to like doing. We saw another staff member who was having a tea break asked a person who was having their breakfast if they could join them and sat chatting with them. We heard another person chatting and laughing with one of the care staff as they walked down the corridor together.

Relatives told us they felt people were treated with respect and their dignity was maintained. Comments included: "They always say before they do" and "Staff seem to respect (family member's) dignity, (family member) seems to like the carers."

However, we also observed practices which were not caring and showed a lack of respect for people. For example, at lunchtime we observed one person who required full assistance from staff to eat and drink. We saw the staff member who was assisting this person left them on several occasions to do something else during which time the person's food went cold. We spoke with a person who had been admitted that day for respite care. They told us they were not happy as on arrival at the home they had been left in a chair in the lounge for over an hour without the pressure relieving equipment they required. Their wheelchair had been taken away and no staff had been to see them. We brought this to the attention of the nurse on duty who took action to deal with this straightaway. We found two people who required regular mouth care were not receiving it and saw their mouths and tongues were very dry. Although staff had been in regularly to see both people, this was not addressed until we raised it with staff. We concluded people were not always treated with respect and their dignity was not always maintained. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of evidence to show how people had been involved in the writing and review of their care plans, and although there were records kept of any contact with relatives we did not see any records of communication about these processes. Care plans contained a generic statement, 'The care plan should describe how to provide the care in accordance with the service user's stated or indicated wishes and preferences, or have evidence of those consulted to act in the best interests of the service user, if the capacity assessment shows they lack capacity in this area.' People, their relatives or other advocates did not sign care plans. One care plan contained information about the person's life, important relationships and treasured memories, however in another we saw most sections had not been completed.

Inadequate

Is the service responsive?

Our findings

At the last inspection we found a breach in regulation as people's care records did not fully reflect their needs. At this inspection, although some improvements had been made, our evidence demonstrated the provider remained in breach of this regulation.

Although some of the care records we reviewed were personalised and reflected people's needs, we found shortfalls in other care records we reviewed. We found staff were not responsive to people's needs and changes in individual needs were not communicated, planned for or delivered.

We looked at the care records for one person whose needs had changed following discharge from hospital five days earlier after a serious illness. Their care plan had not been reviewed or updated and did not reflect their current needs. Staff were not aware of the changes in need as these had not been communicated in the staff handover. We saw the person was not receiving the level of care they required. We found their mouth was dry, and their lips were cracked and crusted as prescribed mouth care had not been given by staff. Staff were giving the person food and fluids via a dessert spoon despite speech and language therapy advice stating a teaspoon was to be used. Staff, including the nurse in charge, were not clear about the amount of thickener the person was prescribed. The care plan stated the person required hourly fluids. We looked at the fluid charts for this person which were poorly completed and showed a daily intake of less than 900mls. There was no evidence to show staff had reviewed the charts or taken any action in response to the person's poor fluid intake.

We saw another person's care plan showed they required regular mouth care as they had a percutaneous endoscopic gastrostomy (PEG), which is a feeding tube that goes directly into the person's stomach, and took no food or fluids orally. We saw this person in the afternoon and their mouth and tongue were very dry. Although the care plan stated staff were to record on a chart any mouth care given, we looked with the nurses who confirmed there were no charts. One of the nurses told us they had used a glycerine mouth swab to moisten the person's mouth that morning and had used another swab when we brought it to staff's attention at 2.30pm. They also told us they had administered prescribed saliva spray but acknowledged this was not signed for on the medicine administration record which showed the spray had last been administered at 6.30am. Another nurse told us the person usually had a mouth tray however they acknowledged this was not in place.

Another person's care plan identified the person was at risk of dehydration and their fluid intake needed to be monitored. The care plan stated if the person had not drunk one litre of fluid by mid-afternoon then their relative should be contacted so they could come in and give the person fluids to prevent a hospital admission. We asked to see this person fluid charts at 3pm and no entries had been made. The staff member told us they were in the process of filling in the food and fluid charts for everybody for that day. They told us they could remember what everyone had had to eat and drink, even though they acknowledged they had made no notes. We saw entries for the days leading up to 18 June 2018 showed the person had a daily fluid intake of less than a litre. For example, on 16 June 2018 the total daily fluid intake was 800mls and the day before that 750mls. There was no evidence to show staff had reviewed the charts or taken any action in

response to the person's poor fluid intake. Following the inspection the provider sent us additional fluid balance charts for this person. However, it was not clear if the amounts recorded on these charts were additional to the amounts recorded on the charts we were shown at the inspection.

We looked at the care records for one person who had a pressure ulcer. This was not reflected in the care plan which had not been updated since March 2018. There was no wound treatment plan to show how often dressings should be changed. Progress notes gave conflicting information. For example, wound care notes showed a small break, yet daily notes for the same day showed the pressure ulcer had healed. The nurse told us they had reviewed this person, and another person who also had a pressure ulcer, and found both pressure ulcers had deteriorated. They made referrals to the tissue viability nurse.

People we spoke with felt there was a lack of activities. Comments included: "You do get a bit bored", "Sometimes we play dominoes or bingo but there are no prizes"; "They do bingo and horse racing with a big piece of paper on the floor but I'm not interested" and "There should be more activities to do, I just sit and watch the TV." Some mentioned the monthly church service held in the home and said they enjoyed it.

An activity programme was displayed in the home. We saw external entertainers were booked and a singer came in on the second day of our inspection. The manager told us care staff were asked to lead activities in the home, however on both days of our inspection we saw little activity for people to engage with. Daily notes we looked at did not evidence a high level of participation in activities. One person's social interaction care plan stated, '(Name of person) spends the majority of time in (their) room. This is where (name) feels most comfortable. Staff should ensure that (name) is asked all the time if (they) would like to participate in any activities. (Name) will often refuse and this should be accepted as it is (their) choice.' We did not see entries in the daily notes or elsewhere to evidence the person was being offered opportunities to participate. We concluded people did not receive care that was personalised or responsive to their needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care plan we looked at contained a detailed plan which could be used to provide appropriate, person centred care at the end of the person's life. We saw this included their wish to receive this care at the home, and who they wished to be informed and when this should be done.

People and relatives told us they knew who to speak with if they had any concerns. The home had a complaints procedure which was displayed. We looked at the complaint records which included a monthly log of complaints. This showed there had been one complaint in January 2018, one in May 2018 and none in February, March or April 2018. Records showed action had been taken in response to the complaints received in January and May 2018. However, another complaint had been raised in June 2018 and although there was a letter responding to the complainant, there was no information to show the concerns that had been raised. This meant we could not establish if the response letter had fully addressed all the issues. The manager told us they had received another complaint which they were currently investigating and we saw records detailing these concerns.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found a regulatory breach as there was no analysis of accident and incidents, some environmental issues had not been remedied and there was no evidence to show the provider was auditing the quality of the service. At this inspection we found improvements had been made in these areas. However, we found continued shortfalls in the delivery of care as evidenced by the regulatory breaches cited in this report. Governance systems were not effective as issues had not been identified or addressed through quality audits. We concluded there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) 2014.

The service did not have a registered manager at the time of the inspection. The registered manager left on 30 June 2017. A temporary manager was appointed on 27 June 2017and they left in February 2018 when a new manager commenced in post. This manager was present on both days of the inspection.

When we inspected it was the manager's first day back after a week's leave. We observed the manager was pro-active in dealing with any issues we raised during the inspection and has continued to send us details of actions they have taken following our inspection and feedback. However, we remain concerned that the provider's own systems and processes had not identified or addressed the issues we found as detailed throughout this report.

We found there was a lack of effective communication between staff which meant information was not passed on and issues were not dealt with. For example, we had found some medicines were not in stock on the first day of the inspection. On the second day of our inspection staff reported at handover that two people had no Paracetamol, and another person's eye ointment had run out. The nurse in charge and staff on the first day of our inspection were not aware of changes in one person's care needs as this information had not been passed on in the handover. No action had been taken in response to concerns raised by staff about the safety of a person when using a stand aid. Food and fluid charts were poorly completed and not monitored and reviewed by staff which meant it was not identified or actioned when people's records showed very little intake.

The manager and team leader were not nurses. A clinical lead nurse who was in post at the last inspection left in March 2018. The manager told us they had recruited a new clinical lead and were waiting for employment checks to be completed before they started their induction. The manager said the team leader was putting a specific induction together for the clinical lead. The team leader was on leave when we inspected and the manager was unable to access the team leader's computer. This meant the manager could not provide us with some of the information we requested such as details of a complaint and the induction for the clinical lead.

Quality audit systems were in place. Some of these were robust and effective, for example the environment and equipment audits. However, we found others these were not always effective in identifying and managing risks or issues. For example, we saw the most recent medicine audits were for March and April 2018. The March audit had not been fully completed and was not signed so it was unclear who had

completed it. The only issue raised in the April audit was a problem with the temperature of the medicine fridge, yet our inspection identified multiple issues in relation to medicines. Care plan audits were completed monthly. These were detailed and identified actions to be taken. However, we found the same actions carried forward in subsequent audits. For example, one person's audit in April 2018 identified the same two issues which an earlier audit in January stated had been completed. We saw records of monthly weights for May and June 2018 which showed one person had lost 8kgs in a month. This was not reflected in the person's care plan or in the monthly weight loss action plan for June 2018. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider looked into this person's weight loss. They sent us records which showed the person's weight had been recorded incorrectly and they had not lost 8kgs.

People, relatives and staff all knew the manager and spoke positively of the improvements that had been made. One relative said, "It has improved greatly since about a year ago in appearance, the carers seem better as well. There is no odour, there are new carpets and wall coverings and they are doing the electrics." A staff member said, "(Manager) works so hard. I have found her approachable and easy to engage with, if you take a problem to her, work or personal, she sorts it."

The analysis of accident and incidents had improved. Themes and trends were identified and any lessons learnt were acted upon.

We saw provider visit reports for February, March, April and May 2018, which showed progress was being made with improvements noted.

We saw minutes from residents' meetings held in March, April and May 2018. These showed activities, meals, care and the environment were discussed and people gave positive feedback. Staff meetings had also been held and the minutes showed the focus of the discussions was on improving the service.

We saw satisfaction surveys had been completed by people who used the service on 16 March 2018. These had been analysed and no issues had been raised.