London Residential Healthcare Limited

Albany Lodge Nursing Home

Inspection report

201 St James's Road
Croydon
Surrey
CR0 2BZ

Tel: 02086844994
Website: www.lrh-homes.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Albany Lodge Nursing Home provides accommodation, care and nursing support to up to 100 older people. At the time of our inspection there were 87 people using the service. The service is delivered over four floors, with two floors offering general nursing support and two floors providing nursing services for people living with dementia.

At our last comprehensive inspection in September 2016 the service was rated requires improvement and a breach of regulation relating to good governance, specifically in relation to care records, was identified.

The registered manager had been in post since February 2016. 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.

Sufficient action had not been taken since our previous inspection to address the concerns relating to good governance. Accurate, complete and contemporaneous records were not maintained in regards to the people using the service. Detailed records were not maintained about the support provided. Robust systems were not adhered to in order to review and improve the quality of service provision.

Staff assessed the risks to people's safety, however, sufficient action was not always taken to minimise and mitigate the identified risks. Risk management plans were not always updated in response to changes in people's needs and equipment was not sufficiently checked to ensure it was used in a safe way.

Staff did not always follow advice and guidance provided by multi-disciplinary professionals which impacted on the quality of care provision, and at times there was a lack of action recorded in response to changes in people's health and support needs. There were varying levels of communication between staff and people which impacted on staff's ability to provide person-centred care.

An activity programme was in place and we observed the activities delivered were well attended and people appeared engaged and enjoying the entertainment. However, for those that did not attend the group activities there was little stimulation and engagement provided. People were often left sitting in silence and staff did not use the resources available to support people living with dementia.

The registered manager had not ensured staff had the knowledge and skills to undertake their duties. Staff had not completed the provider's mandatory training. The registered manager did not assess staff's competency to undertake their duties. Staff did not receive regular supervision and appraisal.

The registered manager had not adhered to the requirements of their registration. They had not submitted notifications about death of a service user or allegations of possible abuse.

People received their medicines as prescribed and on the whole safe medicines management processes were followed. However, we identified that accurate records were not always maintained in regards to the administration of topical creams. Staff adhered to the principles of the Mental Capacity Act 2005 and arranged best interests' meetings for people that did not have the capacity to consent to particular decisions. Staff adhered to the restrictions authorised through Deprivation of Liberty Safeguards (DoLS) in order to keep people safe. Staff supported people with their dietary requirements. A GP visited the service regularly and staff supported people to access healthcare appointments.

Staff respected people's privacy and did not enter a person's room without their permission. People were supported to practice their faith. Staff respected people's wishes in regards to their end of life care decisions.

Mechanisms remained in place to obtain people's and relatives views and opinions. A complaints process remained in place and staff supported people to raise any concerns they had.

Staff were aware of signs of possible abuse and safeguarding reporting procedures. Additional practices had been implemented in response to safeguarding investigations to minimise the risk of harm to people.

Whilst staff were busy and some staff reported they felt their time was pressured which meant at times they felt unable to give dedicated time to certain tasks, we found there were sufficient staff on duty to keep people safe. Since our previous inspection the registered manager had adjusted their process for allocating staff across the home to help with covering staff sickness and improve flexibility in staffing.

Since our last inspection new Directors had been appointed and they were in the process of strengthening the provider's senior management team. This included strengthening systems to review the quality of service provision and increasing the support to operations managers and registered managers.

We found the provider was in breach of legal requirements relating to safe care and treatment, person-centred care, staffing, good governance and notifications. You can see what action we have asked the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. Staff regularly assessed the risks to people's safety but there was not always sufficient action taken to manage and mitigate those risks. There were not sufficient checks in place to ensure equipment was used in a safe way.

Staff were aware of signs of possible abuse and safeguarding adults procedures. Additional practices had been put in place in response to safeguarding investigations to minimise the risk of harm to people.

People received their medicines as prescribed and safe medicines management processes were followed.

There were sufficient staff to keep people safe. The registered manager had adjusted their process for allocating staff across the home to help with covering staff sickness and improve flexibility in staffing. Safe recruitment practices remained in place.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff had not completed the provider's mandatory training and there were not effective systems in place to assess staff's competency. There were a lack of staff support mechanisms in place and staff did not receive regular supervision or appraisal.

Staff adhered to the principles of the Mental Capacity Act 2005 and applied for authorisation to deprive people of their liberty when felt necessary in order to keep people safe.

Staff provided people with meals that met their dietary requirements and supported people to access health services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. There were varying levels of communication between staff and people using the service which impacted on the staff's ability to provide person-centred care. People were not always given choices about day to

day decisions.

Staff supported people to practice their faith and respected their privacy.

Staff provided people with end of life support and liaised with the local palliative care team if they required additional support.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Staff did not always follow advice and guidance provided by multi-disciplinary professionals which impacted on their ability to provide person-centred care. Accurate and detailed records were not maintained about people's needs or the support provided to them.

The group activity programme was well attended. However, outside of this programme there was very little stimulation and engagement for people.

A complaints process remained in place and complaints made were dealt with and responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Sufficient systems were not in place to review the quality of service delivery and mitigate risks to people's health and safety. Effective action had not been taken since our last inspection to ensure accurate, complete and contemporaneous records were maintained.

The registered manager did not always adhere to requirements of their registration and had not submitted notifications about death of a service user or allegations of possible abuse.

The provider had plans in place to further strengthen the management support to the operations and registered managers, including strengthening processes to review the quality of service delivery.

Albany Lodge 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 12 and 13 September 2017 and was unannounced. The inspection was undertaken by two inspectors, a specialist professional advisor with a specialism in nursing 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.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also spoke with a representative from the local authority safeguarding team.

During the inspection we spoke with 17 people, six relatives and ten staff, including the registered manager and members of the provider's management team. We also briefly spoke with two visiting GPs. We reviewed eight people's care records, five staff records and records relating to the staff team's training and supervision. We reviewed records relating to the management of the service and medicines management. We undertook general observations on each floor, as well as using the Short Observation Framework for Inspection (SOFI) in the second floor dining room. We observed medicines administration on the ground floor, the daily nursing meeting and a meeting between the nursing staff and representatives from the rapid response team and the London ambulance service.

Requires Improvement

Is the service safe?

Our findings

When we asked one relative if they felt their family member was safe at the service, they nodded and said, "We are so pleased [their family member] is here."

Regular assessments were undertaken by staff to establish who was at risk of developing pressure ulcers, becoming dehydrating, falling or required additional support to remain safe when transferring and during moving and handling. However, we identified at times sufficient action was not taken to minimise or mitigate the risks identified.

For people that were at risk of dehydration or who required regular fluids to help with their skin integrity and to minimise the risk of pressure ulcers there lacked information about the amount of fluid they required. One person told us, "The staff remind me several times during the day that I should drink because I have a catheter and it will help prevent infection and blockage of the catheter." However, accurate records were not maintained regarding a target fluid intake for people and the amount of fluid they received to mitigate the risk of dehydration or other health conditions related to or made worse by poor fluid intake.

For those at risk of falling, risk assessments had been undertaken around the use of bed rails to establish if these were suitable to minimise the risk of the person falling when in bed. We also saw that some people had their beds lowered and on the whole crash mats put in place to reduce the risk of injury if they did fall from bed. For those that required assistance with moving and transferring, information was included in their records about the type of hoist they used and how many staff they required assistance from. We observed staff supported a person to transfer from a lounge chair to their wheelchair. This was done with patience and clear communication, enabling the person to transfer independently with little staff intervention and at a safe pace. However, there lacked information in some people's records regarding the size of sling and what colour loops to use this meant there was a risk that the sling may not fit the person and support them safely.

We observed for one person their bed rails risk assessment was not updated in response to changes in the support provided. The person had requested to have the bumpers taken off their bed rails as this gave them better grip to mobilise and reposition in bed, but this information was not captured in their records. The risk assessment also did not include any action to mitigate the risk of entrapment in the bed rails now that the bumper was removed.

We observed that whilst people had call bells within reach, some people with dementia were not aware what the call bell was or how it was to be used. Therefore there was a risk that call bells could not be relied upon to summon assistance and there was a risk that people with dementia's calls would not be able to obtain assistance when required.

Checks were undertaken to ensure a safe environment was provided. This included fire safety checks, water temperature checks, gas safety, water safety and electrical safety checks. Whilst there were regular checks on equipment staff did not always ensure equipment allocated to maintain a person's safety and welfare

was used appropriately. One person had been identified as at risk of falls when in bed. Use of bed rails was not appropriate for this person and instead a crash mat was on the floor to minimise risk of injury if they did fall. We observed this person was in bed and their mat had been pushed under their bed and therefore there was a risk that they may injure themselves if they fell. Another person who was using an air mattress told us they were in discomfort and experiencing back pain due to their pressure mattress which also put them at risk of developing pressure ulcers. In both instances we informed the staff about the risk to people's safety and welfare who addressed the concerns identified.

The information in the six paragraphs above show the provider was in breach of Regulation12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Staff reported any incidents or accidents that occurred. We viewed the records which showed incident reports were being completed and reviewed by the nursing staff on duty. Copies of the reports were provided to the registered manager, although we saw that some of the more recent records had not been reviewed by the registered manager meaning there was a risk that appropriate action may not have always been taken to minimise the risk of the incident recurring or addressing any staff performance concerns. We saw that the majority of incidents were due to people falling or slipping onto the floor and from the records it showed no significant injuries had been sustained.

Safeguarding adults procedures remained in place and staff escalated any concerns to the nursing staff and registered manager. Staff took photographs of any bruising people sustained, this included any bruises identified upon admission to the home. The registered manager had records of all safeguarding concerns, including those that had been investigated and the outcome of the investigation, as well as noting those investigations currently ongoing. From safeguarding records we saw that internal investigations had been undertaken as required and any staff performance concerns were being addressed. The registered manager liaised with the local authority safeguarding team to establish how investigations were progressing and identify the learning outcomes. Additional practices had been put in place in response to safeguarding investigations, including the current meetings being held between nursing staff, the rapid response team and the ambulance service. Staff were aware of 'whistleblowing' procedures and how to escalate their concerns if they felt their manager did not take sufficient action to keep people safe.

People received their medicines as prescribed. Medicines were stored securely and at appropriate temperatures. On the whole we observed accurate records were maintained of all medicines prescribed. We identified that for one medicine staff had forgotten to sign the medicines administration record at the time they gave the medicines. They apologised for this oversight and it was quickly amended. However, we did observe varying levels of completion regarding records of topical creams administration. This included barrier creams for those at risk of pressure ulcers. We observed some creams were meant to be administered twice daily, however, records did not evidence this had been adhered to every day. There were regular checks on the stocks of medicines and the checks we undertook showed medicines were accounted for. Safe medicines management processes were followed in regards to controlled medicines, the use of 'when required' medicines and the administration of medicines covertly. Covert medicines is a way of administering medicines usually in food or drinks to people when they are at risk of refusing their medicines and it has been considered in their best interests to take their medicines. There were processes in place for the safe disposal of medicines.

Whilst staff were busy and some staff reported they felt their time was pressured which meant at times they felt unable to give dedicated time to certain tasks, we found there were sufficient staff on duty to keep people safe. In people's records we saw dependency levels were established and regularly reviewed. The registered manager told us they used a basic ratio of one staff to five people and they adjusted this

according to people's needs. For example, additional staff were available if people's dependency level indicated they required a higher level of support or if people needed escorting to hospital appointments. We reviewed the previous week's staff rota which showed the service had the number of staff on duty which the registered manager felt was required to meet people's needs. In addition, the registered manager and nurse leads were often supernummery to provide additional support and enable them to undertake their additional duties.

Since our previous inspection the registered manager had adjusted their process for allocating staff across the home to help with covering staff sickness and improve flexibility in staffing. This process meant instead of staff being dedicated to work on one floor they were able to work across the home and support people on all floors. This process was still relatively new and was impacting on staff's knowledge of the people they were supporting, however, the registered manager felt in the future it would enable staff to gain greater knowledge of the needs of all people and enable staff to support people to work across all floors when this was required.

There continued to be safe recruitment processes in place. This included potential employee's attendance at interview, obtaining references from previous employers, checking nursing staff's NMC registration, viewing people's eligibility to work in the UK and undertaking criminal record checks.

Requires Improvement

Is the service effective?

Our findings

The registered manager's training matrix showed staff were not compliant with the provider's mandatory training meaning there was a risk that staff did not have up to date knowledge and skills to undertake their duties and provide people with appropriate support. For example, out of the 18 nurses only four nurses were up to date with safeguarding adults training, only two nurses were up to date with training on MCA and DoLS, only three nurses has completed training on dementia awareness in the last 12 months and only two nurses had completed medicines administration training in the last 12 months. Of the 59 care assistants recorded on the training matrix we saw 21 were not up to date with their mandatory safeguarding adults training, 27 were not up to date with their dementia awareness training and 37 were not up to date with their fire safety awareness. There were also concerns raised about the level of staff's English and the quality of their spoken English, although some staff did say they were enrolling on a course to improve their English.

At the time of our inspection there were no formal processes in place to review staff's competency. The registered manager told us the nurses would observe the care assistants' competencies and raise any concerns identified, however, this was not formalised. There were no records available to show staff's competency had been formally reviewed to ensure staff had the knowledge and skills to undertake their duties. This included both the care assistants and the nursing staff. The operations director told us there were plans for the provider's clinical lead to implement competency checks.

At the time of our inspection training was delivered through viewing a DVD at the end of staff's shift and then the registered manager held a question and answer session. However, due to the lack of competency checks there were no processes in place to review whether staff had retained the information they had heard. The operations director informed us there were plans to introduce new training resources to further strengthen the quality of training provision.

People were not supported by staff who had adequate supervision to ensure they undertook their duties safely and competently. The registered manager informed us staff were meant to receive formal supervision every two months. However, records showed that this was not maintained. From the service's supervision matrix we saw out of 55 staff, 20 staff had not received any supervision during 2017 and a further 24 staff had only received one supervision session during 2017. This included a lack of supervision for new staff. For example, one staff member started in January 2017 and had not received any supervision. The supervision matrix also had less staff recorded than those on the training matrix meaning not all staff were accounted for on the supervision matrix and therefore there was a risk that more staff were not receiving regular supervision. We also identified that two staff were recorded on the supervision matrix but not on the training matrix, meaning there was a risk there were no systems in place to review their training requirements. We also saw that no appraisals had been completed during 2017.

The provider was in breach of regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

At our previous comprehensive inspection we identified that the environment was not 'dementia friendly'

and did not support the needs of people living with dementia to navigate around the service. At this inspection we observed that the two floors dedicated to supporting people living with dementia had been redecorated providing more pictures and reminiscence objects, there was improved signage with pictures and words and use of colour to help identify key areas for example the bathrooms and toilets. On the first floor one of the communal lounges had been turned into a sensory room, however, we did not observe this room being used. On the second floor the dining room had been decorated to imitate a garden with a water feature and various plants, however, again, these resources were not well used.

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. We saw assessments were undertaken to establish if people had the capacity to consent to certain aspects of their care. Best interests' decisions were made in discussion with people's relatives when people did not have the capacity to consent to their own care.

The registered manager kept track of all applications made to deprive a person of their liberty, if and when the authorisation was granted and when this authorisation expired. The registered manager had recently contacted the relevant agencies as they had applied for a person's DoLS authorisation to be extended and this had not yet been reviewed. For those who's DoLS authorisation had expired and not been re-reviewed staff continued to support them in line with their previous authorisation to ensure their safety whilst they were waiting to be re-assessed.

On the whole people were positive about the food on offer and said there was a variety of meals provided. One person said, "Oh yeh…I enjoy the food very much." Another person told us, "If you don't like what is on the menu they would do something else of your choice. They're very obliging." Staff were aware of people's dietary requirements and provided them with appropriate meals, this included for those with diabetes and those requiring soft or pureed meals. A choice of meals was provided giving people two options at each mealtime. However, we observed there were no pictures of the food on offer and people were not provided with plated up options of the meals on offer to help people with dementia make a choice about which meal they would like to eat.

People had access to health services within the home. The GP visited weekly and opticians, dentists and other health professionals visited when staff made appointments. Staff and relatives also assisted people in accessing healthcare services outside of the home, including accompanying them to hospital appointments when required. We saw examples of where staff were prompt to obtain healthcare support for people. One person was showing early signs of a possible chest infection. The staff liaised with the GP, giving them findings of regular observations and vital signs which enabled them to diagnose a chest infection and ensure the person was treated with antibiotics.

Requires Improvement

Is the service caring?

Our findings

One person said, "Staff are very caring and kind." A relative told us, "[Their family member] is very well cared for and cared for how [they] like." Another person said, "I have a laugh and joke with the staff. They know what I'm like." One relative told us, "The care [staff] are wonderful. Always popping in and saying [to their family member] "are you alright?", "Do you want a drink?"" A third person said, "The staff are kind and caring. They always show respect when addressing me. They are quick to respond to my call for assistance. They mean well and always encourage me. I am extremely lucky to be here."

In spite of the positive comments above, there was varying levels of communication between people and staff observed on the day. On the general nursing floors we observed staff taking the time to listen to what people were saying and using simple and easy to understand language making sure people understood what was said. Whereas, on the two floors for people living with dementia we observed at times people were not communicated with well and their requests for assistance were not always listened to promptly.

We observed that people did not always receive a prompt response to their requests for assistance and staff did not always acknowledge the requests made. We observed on the second floor one person regularly asking to be taken home. Staff were unsure of how to respond and eventually told him he could not go home, but did not engage him in another conversation or around the topic of his home or where he grew up. Later, the same person was asking for a cup of tea. A staff member was in the communal lounge at the time they were asking but this request was either ignored or upon asking for a second time they said they would get him a cup of tea but then did not act on this. Another staff member overheard the person constantly asking for a cup of tea and provided the person with what they wanted. However, we observed the person becoming more agitated by not having his requests acknowledged promptly.

Whilst undertaking our SOFI on the second floor we observed staff starting to move people into the dining room in preparation for lunch. We observed staff pushed people in their wheelchairs to a dining table and then giving a drink, before staff left the room. This was done with little to no conversation or discussion about what was happening or giving the person a choice about where they wanted to sit or which drink they wanted. The staff also did not acknowledge the other people already sitting in the room and left them sitting in silence.

People may have been confused about why they were at the table due to their dementia. We observed some people were sat at the dining table and following 30 minutes of observation there was still no food served and no explanation given by staff as to what people were waiting for. During this time we observed one person became agitated on two occasions and started shouting. On neither occasion did the staff in the room try to establish what was wrong or why the person was shouting. On the first occasion the person was ignored and on the second occasion staff moved the person to another table.

Staff were observed as not always dedicating their time to people when supporting them with meals. For example, we saw one staff member supporting a person with their meal, whilst speaking with another person. They did not engage the person they were assisting in conversation.

People were able to make decisions regarding how they wanted their rooms to look and were encouraged to bring furniture and familiar things from home to make them more comfortable. Nevertheless, people were not always given options and choices about day to day decisions. We observed staff giving people drinks. Whilst there were two options available staff did not give people the option to choose which drink they would like.

The provider was in breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Whilst we observed variations in the level and quality of communication between staff and people using the service, we observed positive interactions and communication with people's relatives. Staff were receptive and welcoming to relatives, updating them on how their family member was and any changes observed in their health needs.

There was a varying level of information in people's records regarding their end of life wishes. Whilst some people had clear documentation with co-ordinate my care records documenting their preferences, this was not available in all records we viewed. Nevertheless, for one person who was receiving palliative care we saw complete records were maintained. An end of life care plan had been developed in liaison with the person and their relatives, this included information about what circumstances a person may require transfer to hospital, their medicines and how to ensure the person remained comfortable and free from pain. We also saw evidence the person's relatives were regularly updated with any changes in the person's condition. Staff had contact with a member from the specialist palliative care team should they require it to further support this person.

There was a funeral for one of the people who had recently passed away on the first day of our inspection. The registered manager attended the funeral and took flowers on behalf of the provider and all the staff. A memory tree was displayed in reception with pictures of people who had passed away to remember them.

Staff provided people with any support they required with their religious needs. One person told us, "My priest comes every fortnight. My faith is everything to me." A weekly catholic service was held which people were welcome to take part in. The staff said they were also able to arrange for other religious leaders to visit the service if people wanted them to.

Staff respected people's privacy. We observed staff knocking on people's doors before entering. Staff supported people with their personal care needs in the privacy of their bedroom or bathroom.

On the second floor we observed an incorrect date being displayed which may have caused confusion for people who required orientation to time. On Wednesday 13th September 2017 the date was displayed as Tuesday 12th October and that the season was Spring.

Requires Improvement

Is the service responsive?

Our findings

We observed people's personal care needs were met. People were well dressed in clean clothes, hair washed and brushed. There were no malodours and people's continence needs were met promptly. One person's relative told us, "They've done a fantastic job here. I'd say [their family member's] dementia had improved. In hospital [they] were always complaining of pain, but now she's more active and her mind occupied she seldom mentions it." Another person said, "I consider myself very lucky to be here…I receive whatever care I require."

From speaking with staff and reviewing wound care charts we saw people received support in regards to wound care and the treatment of pressure ulcers. Staff followed advice provided by the tissue viability nurse (TVN), provided appropriate dressings and regularly reviewing the wound. We saw that for those that had pressure ulcers these were healing. People with pressure ulcers who had capacity were able to tell us that staff came to support them to reposition. However, this was not evidenced in care records and accurate recording was not maintained. On the whole staff followed the advice provided by the TVN. However, we saw for one person the TVN advised staff to make a referral to podiatry services. The staff were not able to provide evidence that this referral was made and a podiatrist had not been to visit the person. This meant there was a risk the person did not receive adequate foot care.

Whilst we saw staff regularly checked people's blood sugar levels for people with diabetes, there was a risk that people would not receive appropriate support regarding their diabetes because of poor record keeping. Staff had not received specific training regarding diabetes care and there was no involvement of the diabetic nurse or dietician in the care of people with diabetes. For one person with diabetes we saw their care records did not contain information for staff about recognising signs that a person had high or low blood sugar levels and what to do if this occurred, or what was a 'normal' blood sugar reading for that person. People with diabetes are at risk of complications regarding their feet and sight due to poor circulation and nerve damage, however, people's care plans did not contain information regarding annual eye screening or foot care and there was a risk that this need was not met.

The care plans did not provide consistent and coordinated information about a person's needs. For example, some people were at risk of urinary tract infections and becoming constipated. There was no information about how this was being managed and mitigated. Another person's records showed they had lost 7kg in 10 months and in June 2017 their BMI was 15. There was no recent weights recorded and there was no information in their care records about what action was taken in response to this weight loss.

One person's care records stated they could be resistant to receiving support with their personal care and that staff should support them in line with information in the "traffic light behaviour support system" as recommended by the Care Home Intervention Team in April 2016. However, we did not observe support being provided in line with these guidelines, particularly around meal times. Whilst this person's care plans had been updated at regular intervals there was no information to indicate that the "traffic light behaviour support system" should no longer be in use and there was a risk that this person may become more agitated and frustrated by staff not following the guidance provided. For another person we saw they did receive

appropriate support with their behaviour management and we saw that guidance provided by the care home intervention team was being used. This was particularly in regards to when the person displayed behaviour that challenged staff and an ABC chart was being updated, so the staff together with healthcare professionals could further understand the triggers to this behaviour and how to reassure and minimise the presentation of this behaviour.

From our observations we saw the group activity programme was well-attended and people enjoyed the sing along activity being delivered. Staff and people were dancing, clapping along, playing percussion instruments and singing along to the songs. One person said, "They do lots here to keep everyone interested." However, staff did not always know the people they were supporting and this limited their ability to provide person-centred care. We overheard two staff discussing who may like to participate in the group activities. One staff member asked another, "Which usually go down for activities? Which patient?" The other staff member replied, "I don't know. This is not my floor." Neither of the staff members asked people themselves who would like to participate in the activity or discuss what activity was taking place on the other floor. This led to no-one being invited to participate in the group activity and a risk that people would become bored and isolated.

For those that were unable or did not wish to participate in the group activity programme there was very limited opportunities for stimulation and engagement. During observations on the first floor we observed people spent most of their time either in the main lounge or in their rooms. In the lounge there was no auditory or visual stimulation and during our observations staff did not engage people in one to one or group activities or conversations. There was a sensory room as well as another smaller lounge on the first floor, however, these were not used during our inspection and staff did not make the sensory resources available in these rooms available for people to enjoy.

Staff did not always provide people with the level of support they required, particularly in regards to their dementia. We observed one gentleman in the dining room on the first floor picking up and gathering the tablecloths on the dining tables. A staff member came and stopped the gentleman from doing this. However, they did not spend time identifying why the person was displaying this behaviour, distract them or offer them an alternative activity or resource to interact with.

Care records identified some brief information about people's interests and hobbies. However, we found that this information was not always used to engage people. For example, one person's records stated they liked horse racing and watching TV. At the time of inspection they were in their room with no TV or radio on. Their records of daily activities showed that for the month of September they had only either had their personal care needs met or were 'resting'. It did not record any activity or stimulation being provided

The provider was in breach of Regulation 9 of the HSCA (Regulated Activities) Regulations 2014.

Accurate and complete care records were not maintained in regards to the daily support provided to people meaning there was a risk that people were not receiving the level of support they required to meet their needs and maintain their welfare. Some people needed staff to support them to reposition and encourage them to drink regularly due to associated risks to their health. However, staff did not maintain consistent and accurate records to track when a person was supported to reposition or the amount of fluids they consumed and there was a risk people were not receiving the level of support they required.

We were told by the registered manager that one person had a current urinary tract infection and this was confirmed by the nurse supporting the person. This infection was not mentioned in their care records about how this was being treated or what action staff were to take to prevent recurrence. There was no target fluid

intake and no fluid intake records were maintained to minimise the risk of the infection recurring.

Some care records also contained conflicting information. For example, one person's records had conflicting information regarding their 'Do Not attempt Cardio Pulmonary Resuscitation' status, which meant there was a risk their wishes may not be respected in the event of a medical emergency. Other records were not fit for purpose and were not completed correctly. For example, we saw that some forms recording people's vital signs did not enable both the time and temperature to be recorded. This meant part of the information important for monitoring people's health was often missing.

The provider was in breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

A complaints process remained in place and the complaints procedure was displayed in communal areas so people and their relatives were informed about how to make a complaint. People we spoke with were aware of how to make a complaint and those that had made a complaint were happy with how it was handled and the outcome. From complaints records we saw that staff raised complaints on people's behalf and recorded any concerns people spoke to them about. All complaints received were reviewed, investigated and responded to by the registered manager. When complaints identified that a staff member had not supported a person appropriately, they apologised to the person involved and staff received additional supervision. In addition to the complaints received, we saw that compliments were also recorded. One relative wrote, "Thank you to you all for the kindness and care you gave [their family member]."

Requires Improvement

Is the service well-led?

Our findings

One relative said, "[The registered manager] is a nice guy, seems genuine." A person told us, "I see the manager every day. He's very approachable."

At our last comprehensive inspection a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014. This related to good governance and in particular ensuring accurate records were maintained about people's care. The registered manager informed us since the 2016 inspection they had reminded all staff through staff meetings and supervision about the importance of accurate record keeping and delivered training on records. However, we observed that staff meetings and supervisions were very infrequent and the provider was not up to date with their mandatory training so there was a risk that this information was not regularly emphasised to all staff. The records from staff meetings showed that staff were reminded about good record keeping, however, since our last comprehensive inspection there had only been one meeting held in July 2017.

The registered manager told us they delegated the task of ensuring accurate care records to the nursing staff and whilst a check was undertaken to ensure all aspects of the care record were available, including care plans and risk assessments were in place, there were no formal care records audits and no processes in place to reflect on the quality of care recording. We found there continued to be concerns regarding the quality of care records and accurate and complete records were not maintained about people's care. This meant there was a risk that staff did not have the information required to meet people's needs.

The registered manager had processes in place to review the quality of service provision, however, this were not always adhered to or effectively used and there was a risk the registered manager would not identify and address concerns regarding the quality of care delivery. This included weekly reviews of any infections people acquired, pressure ulcers and any hospital admissions, as well as undertaking audits in regards to call bells, maintenance, health and safety, infection control and medicines administration. However, we saw that the infection control audit had not been completed since November 2016 and therefore processes were not in place to identify and address the areas we saw requiring improvement, including ensuring people's individual chairs were regularly cleaned. Bed rails and mattress checks were undertaken to ensure these were appropriate and in safe working order. However, it had not identified that one person's mattress was not working appropriately and that person was left uncomfortable and in pain.

The registered manager kept a log of all incidents that occurred, however, these had not been updated since May 2017. Similarly, a log of all complaints received had not been updated since April 2017. There was a risk that the registered manager was not aware of any current themes or trends which may indicate a person requires additional support in order to keep them safe and mitigate any risks to their welfare.

The provider remained in breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The provider displayed their performance rating from their previous inspection at the service as well as on their website. A copy of the previous CQC inspection report was available in the reception area for people,

their relatives and visitors to read. The provider was open about their current rating and the findings of their previous inspection. Nevertheless, the registered manager had not adhered to the requirements of their registration with the Care Quality Commission. The registered manager had not submitted notifications about all deaths or safeguarding concerns raised as required by law, this included the two recent deaths and five of the current open safeguarding investigations.

The provider was in breach of regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

There were mechanisms in place for people and their relatives to feedback about service provision. This included completion of a bi-annual satisfaction survey. We viewed the findings from the December 2016 survey. This showed 85% of people rated the service provided as either good or excellent. Some of the comments included, "We're happy that mum is being cared for in such a nice place with very good staff." Areas for improvement were identified as providing more activities and stimulation for people that spend much of their time in their rooms, cleanliness of the service and making the environment was dementia friendly. Whilst some improvements had been made since the inspection in regards to the environment, we continued to identify a lack of engagement and stimulation for people that were not able to or did not want to engage in the group activities on offer.

Daily meetings were held between the registered manager and the nursing staff on duty. These meetings gave staff the opportunity to update each other on people's needs, and changes in a person's need, discuss any multi-disciplinary support the person may require and organise for staff to support with GP or hospital appointments. These meetings were also used to update each other on any process changes. For example, there was a going to be an imminent change of pharmacy and so staff reminded each other about ensuring any repeat prescriptions were ordered so people had their medicines. One staff member told us, "This meeting ensures that there is good communication within the unit between all staff. It gives people a snapshot of what has gone on in the last 24 hours and plan ahead." On the second day of our inspection we saw the registered manager used these meetings to remind staff of the importance of adhering to supervision arrangements and the importance of maintaining accurate records following feedback we gave at the end of day one of inspection.

The provider currently holds management meetings. In addition to these, smaller management meetings were planned with the registered managers in the local area to enable them to discuss common challenges and share best practice. The operations support manager felt these smaller meetings would provide registered managers with greater opportunity to discuss challenges common to the local area and give managers the opportunity to speak openly and support each other to problem solve.

We received a mixed response from staff about their morale and the level of support they received from the registered manager. Some staff felt unable to have open and honest conversations with the registered manager and felt it would impact on them negatively if they spoke up. One staff member felt there was no recognition for going above and beyond. We heard from staff that they felt staff sickness had increased and this was impacting on staff morale. We spoke with the registered manager about sickness levels who told us they had no systems in place to monitor sickness rates to establish any trends or increase. Whereas, other staff felt well supported by the registered manager. One staff member told us, "[The registered manager] is a good listener…patient and he knows his stuff. He always seems to have time for you."

Since our previous inspection new Directors had been appointed and there had been the introduction of new senior management positions to strengthen the management and leadership of the provider. This included the introduction of an Operations Director and Compliance Manager. With these positions a new

quality assurance system had been introduced which enabled key service data to be recorded and reported to the senior management team. This system was in its infancy and there were plans to further formalise and strengthen this system. The registered manager and operations support manager felt the addition of these positions had offered them further support and they felt any concerns or requests raised were being listened to and acted upon. The provider was also introducing further HR support to registered managers and operations support managers to provide them with the knowledge and skills to undertake effective staff management.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered manager had not informed the Care Quality Commission about the death of a service user. 16 (1)

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 The registered manager had not informed the Care Quality Commission about any allegation of abuse in relation to a service user. 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured service users received appropriate care that met their needs and reflected their preferences. 9(1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not assessed the risks to people's safety and mitigated those risks, including ensuring equipment was used in a safe way. 12 (1) (2) (a) (b) (e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured effective systems were in place to assess, monitor and improve the quality of care and to assess, monitor and mitigate the risks to service users. The provider had not ensured effective systems to ensure accurate, complete and contemporaneous records were maintained. 17 (1) (2) (a) (b) (c)

The enforcement action we took:

A warning notice was issued.

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 The registered manager had not ensure staff received appropriate support, training, supervision and appraisal to perform their duties. 18 (2) (a)

The enforcement action we took:

A warning notice was issued.