Lifeline Nursing Services Limited

St Claire's Nursing Home

Inspection report

Birchwood Avenue
Doddington Park
Lincoln
Lincolnshire
LN6 0QT

Tel: 01522684945

Date of inspection visit:
01 November 2016
03 November 2016

Date of publication:
02 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected St. Claire's Nursing Home on 1 and 3 November 2016. This was an unannounced inspection. The service provides care and support for up to 40 people. When we undertook our inspection there were 35 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

The provider is currently in administration and a management company is overseeing the running of the homes in the group. The management company keeps CQC informed of progress and their visits to the homes and ensures we have an up to date action plan for each location.

There was not a registered manager in post. 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. A new manager had just been appointed.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was one person subject to such an authorisation.

We found that there were insufficient staff to meet the needs of people using the service. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed and care planned, but not delivered in a consistent way. People and relatives were not involved in the planning of their care and had not agreed to the care provided. The information and guidance provided to staff in the care plans was clear but not always followed through in the records. Risks associated with people's care needs were assessed, but the plans were not always followed by staff. This could put people at risk of harm.

You can see what action we asked the provider to take at the back of the full version of the report regarding insufficient staffing levels and the use of care plans to monitor people's needs.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their

care and their lives.
Activities were on offer for people to take part in, which some people declined, but others enjoyed. People had the opportunity to join a residents committee.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements. Some checks were not robust enough and senior staff did not highlight mistakes to staff to ensure people were safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Checks were made to ensure the home was a safe place to live.

Insufficient staff were on duty to meet people's needs.

The recording and updating of risk assessments for people was poor.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not planned and reviewed on a regular basis with them.

Activities were available for people to take part in, but some people declined. They were not always aware of forth coming events.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance. However, analysis of some audits were not robust.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

There was not a registered manager in post which is a condition of the provider's registration.

St Claire'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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 3 November 2016 and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to four health professionals during the site visit.

During our inspection, we spoke with eight people who lived at the service, three relatives, three members of the care staff, a housekeeper, two activities organisers, a cook, the hairdresser, the administrator, the deputy manager and the registered manager. We also spoke with the area manager for the management company overseeing this home. We observed how care and support was provided to people.

We looked at eight people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the

manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

The manager told us staffing levels were calculated using people's dependency levels and daily care requirements. However, there was no indication of when the dependency levels had last been calculated and they showed that there were 21 people who had low dependency needs. We could not determine how often the dependency tool was reviewed as there were no dates available. This did not match the views of the staff caring for people. One staff member told us, "It's not [fully] staffed every day. The dependency is higher now out of 35 people only seven can manage on their own." This concern was expressed by three other members of staff. This meant that the staffing levels calculated by the manager were underestimating the numbers of staff needed to provide safe care.

The manager was able to show us the staff rotas from 17 October to 30 October 2016. However, inconsistent recording meant we were unable to use them to monitor if shifts were fully covered and staff could not remember whether gaps in the rota had been filled. While the manager tried to fill staffing shortages by using agency staff, staff told us that it was unreliable as sometimes the agency could not supply staff. People we spoke with told us their needs were not always met and staff told them when there was a shortage of staff.

Other methods which had been in place to monitor if people's needs were being met in a timely manner were now not being completed as the call bell monitoring company were to provide software to monitor the calls. An example of this was an audit to monitor how quickly call bells were answered. The timely response to call bells was important to people who either through choice or because they were ill choose to remain in bed or in their bedrooms. People we spoke to told us that while staff were always polite they sometimes took a long time to answer the bells.

Staff told us that the staffing levels were not good at times and this impacted on the care they were able to give people. One staff member said, "Staff go off sick, we know that, but when you can't get others to fill in the gaps its harder work than usual." Staff told us they had raised their concerns staffing levels, but they had not seen any improvements.

People we spoke with voiced concerns over staffing levels and the impact this made on their care needs. This was especially so for people who had mobility problems. One person would not comment on staffing levels specifically, but went on to tell us how distressed they had become in the evening when they wanted to use the toilet, but could not summon assistance. Another person said, "It depends on how much they've got to do." Commenting on call bells being answered another person told us, "Anytime from a couple of minutes to three quarters of an hour." At lunchtime we observed people having to wait to use the toilet after lunch was served. This made people anxious as going to the toilet quickly was important to them. A lack of staff could result in people not having their needs met and becoming distressed if they had to wait for assistance

This is a breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. However, the recording of how staff could encourage people's independence and the assessment of each risk varied. For example, where people had a history of mental health problems. Staff had recorded when advice had been sought from the community psychiatric nurses. A general risk assessment was in place for each person regarding bathing and showering. This referred to water temperatures, burns and scalds.

Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. Permission for the use of bedrails had been sought of people who could make those decisions, but no best interest decisions for those who lacked capacity to make decisions. Staff had also not taken into consideration the height differential between the top of the mattress and the top of the bed. There is a required height differential which was not being adhered to and therefore the person could be unsafe in bed. We also observed that one person had been assessed as needing bedrails, however only one rail was in place. This was not on the side of the bed where the person was at risk of falling out. This made this bed unsafe for the person. We pointed this out to staff, who corrected the bedrails on the bed.

The home had hoists and slings to aid with mobility. An external company had undertaken examinations to ensure the hoists were safe to use. There was a recommendation that a 19 year old hoist be replaced within six months, but this had not been actioned by the provider. Although the provider told us it was no longer in use, staff indicated that they were still using it and there was no note on it to remind them it should not be used. There were also no internal checks taking place for the safe use of the hoists and slings by staff. So staff had no way of knowing if they were safe to use and what to do if a piece of equipment was not fit for use. Although the provider told us that hoists were checked by the maintenance team, these checks were not recorded so the provider had no system for assuring themselves that these checks were being undertaken. This could put people at risk of harm when moving them about the premises. We also observed staff were not always diligent of where they left hoists after use. For example, one was left immediately outside a person's room. This was a trip hazard as staff left this unattended. Where air flow mattresses had been prescribed for people with skin integrity problems there was no assessment of how staff had made this decision. Staff were not recording the setting required and the frequency of checking the setting. This could mean that people were resting on mattresses not suitable to their specific needs and be at risk of developing pressure ulcers.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because of poor mobility or memory loss. However, these did not contain photographs to aid identification when evacuation took place. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

We were invited into five people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. However, staff had not taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision. This did not ensure rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair.

The entrance to the home was through a door, which was open at all times during the day. There was a receptionist on duty during the day, who we saw reminding visitors to sign in the visitors' book. People told us they could exit the building if they wished by using the latch on the door and told us they reminded staff they were out of the building. All areas of the garden were safe to walk in and there was no direct entry to the

gardens from the main road. It was possible for people to have locks on their doors, but at the time of the visit no one wished to use this option.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. Some people choose to have pictures on their doors which meant they could recognise them quickly. There were also signs on the doors indicating what each room was used for, for example, a toilet. The signs were in words and pictures. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be. One person said, "Fortunately you can go around in a circle and come back to the same place."

People and relatives told us they felt safe living at the home. One person said, "People look after me all the time. Another person told us, "It's ok, safer than at home." People told us that staff were caring when attending to their needs. People also told us they felt their belongings were safe. They told us that staff made checks on them day and night to ensure they were safe and if they wanted anything. They said they did not object to this as it made them feel safer.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was no process in place for reviewing accidents, incidents and safeguarding concerns to identify trends and ensure remedial action was taken to prevent a reoccurrence. However, staff told us that accidents, incidents and safeguarding concerns were discussed at each shift handover and also discussed at staff meetings. We saw the minutes of the staff meeting for March 2016 and July 2016 where such matters as possible poor practice had been discussed with staff. It is the responsibility of the provider to review and monitor falls, incidents and safeguarding. The local authority might review this for their own contract monitoring purposes but it is the provider's responsibility to have their own systems in place.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were some current staff vacancies, but there was a recruitment drive in place with local agencies to find new staff. The provider had just commenced a new auditing tool for staff personal files. Each current staff member's file was being reviewed and thereafter a check would be in place as soon as new staff commenced employment.

People told us they received their medicines each day, but the times had recently changed. One person said, "It used to be 8am, but now I get this medication at around 11am." The person did not know the reason for the change. This could have an impact on their treatment as some medicines are required to be administered at set intervals and some with food.

Medicines were stored in line with current guidance. Each person had a locked cupboard in their bedroom where their medicines were kept, plus storage space in the main medicines storage room. Staff told us that medicines stored in people's bedrooms was a more personal touch as the use of a trolley was too clinical. The temperature of the refrigerator and storage room were checked daily and staff were able to describe what they would do if the temperatures were not within the desired ranges. This is an improvement in the

knowledge base of staff on the safe storage of medicines. A record book was in place for those medicines requiring special storage and administration. The entries followed current guidance. Records about people's medicines were accurately completed. Each medicines administration record (MAR) had a photograph of the person, which bore a resemblance to that person plus other information such as allergies. Protocols were in place for the use of medicines such as paracetamol, which the GP requested be given when required.

Medicines audits we saw were completed by staff at the home and the pharmacy supplier. The last audit under taken by the pharmacy supplier in September 2016. There was only one action which had been completed. The manager had also had a meeting with the pharmacy supplier in September 2016, where ordering, supplies and other information was shared. Staff told us this had improved the services being offered by the pharmacy supplier and had clarified protocols between them. The last internal medicines audit had been completed in May 2016 and all actions had been completed.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. We had observed during the morning that the first round of medicines did not finish until 11am, when staff had commenced the round just after 8am. Staff told us this was because they had been disturbed and had to attend to other tasks during that period. We pointed this out to the manager who intended to complete some spot checks so that staff would not be disturbed as this had the potential for mistakes to be made. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Good

Is the service effective?

Our findings

People talked about the ability of staff having the skills to look after them. One person said, "More staff training goes on." They told us they had confidence in the staff to look after them.

Two staff told us about their induction process. They told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of, which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The manager informed us they were assisting staff to complete the Care Certificate, which was being used as part of the staff induction process.This would give everyone a new base line of information and training and ensure all staff had received a common induction.

Staff said they had completed training in topics such as manual handling, health and safety and food safety. Some staff had completed training in particular subjects such as dementia awareness. They told us training was always on offer and they had been encouraged to complete courses to enhance their knowledge about how to look after people. The training planner gave details of all the courses staff had completed and highlighted those that staff required to update. Any shortfalls of staff not attending courses were addressed at staff supervisions. There were several topics of training advertised for staff to attend.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the manager and deputy manager at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. Staff had received at least two formal supervisions since January 2016 and their yearly appraisal. Staff told us at the yearly appraisal their previous year's record of service, training, conduct and goals were discussed. They told us there was opportunity to voice their concerns and views.

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). At the time of our visit there was one person subject to such an authorisation.

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 found that the provider had followed the requirement in the DoLS. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff were able to explain how a person could be deprived of their liberty and what steps to take if people could not make decisions for themselves.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had also been consulted. These covered areas such as maintaining their personal hygiene, control over their personal finances and road safety. However, we did not see any in place for people who required medicines to be administered to them and could not make those decisions for themselves.

People told us that staff always asked for their consent before treatment commenced and support was given. One person said, "They ask me whether they can come in to my bedroom." Another person said, "Staff ask me when I want a bath, if I've got everything I need to wash and help me sort my clothes." People said staff knocked on doors before attempting to enter a room and we observed this practice. They told us they had freedom of movement, but always told staff when they were going out with friends and relatives.

People told us the food provision was good and varied. They told us that if they wanted a different choice to the menu staff would obtain it. One person said, "The food is good no complaints." Another person told us they felt the food was, "Ok." People told us that at meetings they had asked for more variety and this had been incorporated in the menu. Comments included, "Staff are listening."

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required plus portion sizes. Kitchen staff were not aware of how the nutritional content of meals could affect tissue viability and medicines interaction for people, which could affect people's health. We pointed out to the manager that it was not good practice for those preparing and serving food to wear jewellery as items could easily fall into food. The manager addressed this issue immediately.

Menus were not on display in dining rooms, but staff told us that very few people used the dining room and they had been spoken with individually about the meals that day. However, this meant people could not use the menus as a reminder to the day's choices. Only five people used the dining room, no staff were present as most people did not require assistance. One person was in danger of spilling a hot drink on themselves and a member of the inspection team intervened. When staff were altered they attended to the person's needs. People and staff told us it was individuals choice where they had their meals and most preferred to eat in private.

Meals were taken to rooms by staff. Food all had covers on when brought from the kitchen and were individually named. We observed staff assisting people to eat and drink in an unhurried way and maintaining eye contact. We saw hot and cold drinks provided throughout the day and jugs of water or juice put in people's rooms.

People told us staff obtained the advice of other health and social care professionals when required. One person told us, "When I want a nurse they call one. It's out of staff hands when they come of course." Another person said, "If I need to see my GP I can phone or staff will. They are good like that." They told us if their relatives could not escort them to appointments staff would try and attend.

In the care plans we looked at staff had recorded when they had responded to people's needs and the action which had been taken. There was evidence that people were being referred to the wider multi-disciplinary team such as a chiropodist and opticians. Several people had hospital appointments which they

had attended. Staff had recorded outcomes of those visits.

Good

Is the service caring?

Our findings

People told us they liked the staff who were kind and helpful. One person said they were looked after by, "A wonderful bunch of girls." Another person told us, "We can ask them anything and they will get it." People told us staff treated them with dignity and respect at all times. We observed staff taking care when using hoists and slings to preserve people's dignity and assisting someone to adjust their clothing which was in disarray after the person had visited a toilet.

The people told us they were supported to make choices and their preferences were listened to. One person said, "I can get up when I want to." Another person described how they spent their day and told us they could do what they liked and staff respected their wishes. They said, "I have my quiet days and others I just want to rush and do everything at once. Staff help me to be rational so I don't get too tired, but if I still wanted to do those things I could do."

People were given choices throughout the day, if they wanted to remain in their rooms or bed or where they would like to sit. Very few people joined in events in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff. Staff offered each visitor refreshment and were pleasant and smiling as they went about their work.

All the staff approached people quietly and altered their tone of voice to suit each person. If a person was hard of hearing and could lip read, staff positioned themselves in front of the person and spoke clearly. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone was anxious about their state of health. Staff asked whether the person would like to speak in private and closed their bedroom door before carrying on the conversation. A staff member was seen in a corridor talking animatedly with a person who was telling them of their childhood.

Throughout our visit we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

People and relatives told us they could have visitors whenever they wished and this was confirmed by relatives. One relative said, "I come all hours of the day and are always welcomed." We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families and friends visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. We saw one staff member helping someone to telephone a friend. They were patient with the person and withdrew once the conversation had commenced to allow the person privacy.

Staff always acknowledged people when walking around the building. They greeted people with their first names if this was their wish. They knew lots of information about each person so could open a conversation

easily with each person. People told us they did not have to divulge information about themselves to staff, but did so willingly. One person said, "We are like a family here."

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities. This home is part of a small company so the manager had the opportunity of meeting with other home's managers, area staff and head office staff on a regular basis.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy on display. There were no local advocates being used by people at the time of the visit.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they were involved in the care planning process and people told us they were not asked whether they would like to contribute to their care plans. In the care plans we reviewed none had indications that the person or their advocate had been consulted about the care and treatment they were receiving. People were therefore not offered the opportunity to discuss their care needs and input into how care could the tailored to meet their personal needs

We saw that care was delivered in a way that was more task-focused than person-centred. Staff had checklists to follow to ensure that people received all their care in line with the care plan. For example, there was a list of people who would be having a bath or shower that day, but no indication if this was the person's preferred day to have a bath or shower. Staff told us it was easier to work off that type of list so each person had a bath or shower at least once a week. Staff told us people could have them whenever they wished, but only weekly baths and showers were recorded in the care plans. Refusals of people were hardly ever written down.

In six care plans we looked at people had Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR). In most cases the DNACPR forms had not been correctly completed. For example, one resident had the wrong address on the form. There was no date on another form and in one care plan there were two DNACPR forms, both giving different details. In each of the incorrect forms seen this would make the forms invalid and therefore staff would have to attempt CPR, which may be against their wishes. Staff were not aware of this and the manager took remedial action with the GP surgery to have the forms corrected. It is not the responsibility of the provider to complete forms, but to monitor them and bring them to medical practitioners' notice.

The care plans we looked at included assessments such as people's mobility, nutrition, communication needs and personal hygiene needs. However, some evidence was the same in each section for different people. Therefore they were not person centred. They also did not always contain the correct information to ensure staff followed safe procedures when delivering care. For example, the staff were reliant on the community nurses in relation to tissue viability. A community nurse could enter the home, give treatment and eave. Health professionals we spoke with told us staff were unaware of what to ask the community nurses and staff confirmed that statement. Therefore they would not know how to continue to monitor each person's condition. We did see suitable equipment in place to help maintain people's skin condition. This included special beds, pressure relieving mattresses and cushions. We saw special boots were in place for one person who required additional protection of their pressure ulcers. However, staff had not recorded in the care plans how they were ensuring the equipment in use was still necessary for each person. Charts were in place if people required to be repositioned in bed. Staff were not always keeping to the times stated on people's care plans. For example, one person required to be repositioned every four hours. Over two days staff had only recorded they had repositioned the person three times each day, not six times. This could put this person at risk of developing pressure ulcers. Therefore people's care could be compromised if staff did not adhere to the needs, wishes and prescribed treatment for people.

People were weighed, where possible, at least monthly. Staff recorded the details in the majority of care plans. However, in one care plan we saw a person required monthly weights, but the weights had not been recorded since July 2016. We saw weights recorded on a board in a staff area, but staff could not tell us when they had taken place. This meant staff did not know whether the person's weight had increased or gone down and could not help them to adjust their nutritional intake accordingly. When people required their fluid and food intake monitoring the recording was spasmodic by staff. On one chart staff had not made many entries of the person's fluid intake and not recorded how much the person required to take in each day. The intake was low so the person could be at risk of dehydration. Staff therefore did not have up to date information on whether a person's diet was helping them maintain good health.

The care plans had not been updated monthly, which was the minimum amount the provider required. At times the entries were not legible and the daily report notes only gave basic information about each person's day. They did not refer to the charts in place for people and if more or less observations were required, even when changes had taken place. Health professionals we spoke with gave us mixed views of the staff capabilities of following instructions. For example, a failure to ensure people had the required supplements to their diet to promote good wound healing. They told us staff knew what to do, but did not always record their actions. A failure to ensure the care plans were up to date could result in people's current needs not being addressed and put their health and well-being at risk.

This is a breach of Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

The people we spoke with told us they were happy with their care. One person said, "I'm comfortable to say if we're unhappy." Another person told us, "We won't be ignored they will discuss it."

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was a good method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use for reminding staff of tasks yet to complete, such as calling a GP or ordering medicines.

People told us about their involvement in activities. Some people told us they liked their own company, others enjoyed certain activities, but there were few days out. People were not aware of activities which we saw advertised on notice boards about forth coming events. Although one person described a recent visit to a fish restaurant which they had enjoyed. One person said, "I don't like group events and it's mainly that which is organised so I read and watch my TV." One person said, "Activities are not stimulating or challenging enough, there are no rewards. They're not gender specific just not challenging. The bar is set too low."

We were informed that two part-time activities co-ordinators were employed and they were present during our visit. An area called the Lancaster Lounge was used as a separate activities room. We saw records of a variety of activities and events which had been organised, but no analysis if these had been successful. Events included fashion outlets attending for purchasing sessions, games afternoons and art and craft sessions. Staff had not explored whether people would like to pursue individual hobbies and interests.

The activities co-ordinator kept a folder for each person. This included the activities people had been involved in. Staff told us they could then see if people were becoming isolated. The staff and people living in the home and relatives had raised money to support the activities programme. A funding raising committee had been formed between people who lived at the home, relatives and staff who would decide how the money could best be spent. Provision was being included for those people to benefit from the money raised

who did not wish to take part in organised activities.

People were actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. People told us when they had raised a complaint and if they had received a satisfactory outcome. One person said, "I am confident to raise any complaint to the manager."

We saw the complaints procedure on display. The complaints procedure contained information about CQC and about the local ombudsman who could help people with their concerns. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meeting in May 2016.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. A new manager had recently been appointed and was settling into their new role. People told us they could express their views to the manager and deputy manager and felt their opinions were valued. People told us the manager was visible and approachable. One person said, "I'm quite happy with the manager now who comes down to chat." People told us the home had improved since March 2016.

There was sufficient evidence to show the manager and deputy manager had completed audits to test the quality of the service. These included infection control, financial audit and a maintenance audit. Where actions were required these had been clearly identified and signed when completed. However, the care plan audit had not identified record keeping such as better recording of fluid and food charts. Staff did not always follow the advice in the care plans through to daily charts and observations and this was not monitored by senior staff. Where people had expressed concerns their care was not being delivered, due to having to wait for staff to help them, this was not taken into consideration when suitable staffing levels were being calculated. Although the manager told us following the inspection that regular uniform checks were undertaken, on the day of our inspection we saw that staff were not adhering to infection control standards by wearing jewellery. An analysis had not taken place for all audit checks and the lack of staff meetings and from information given to us by people, relatives and staff this was not always passed on.

The management company currently overseeing the home had produced an action plan for the manager to follow. This covered areas such as care plan reviews, staffing levels and staff personal files. When completed the actions were signed off by an area manager. The management company kept CQC in touch with the progress of the action plan on a regular basis. The action plan dates had been revised for some items due to a change of manager, so there were still a number of actions still to be completed.

A resident's involvement file was kept. This contained details of questionnaires which had been sent out in August 2016 and September 2016. The results were displayed in the reception area with positive actions which had taken place, such as a menu review. This also contained the minutes of the residents committee and how the selection had taken place. Where actions were required these were to be signed off by the manager. Analysis of small questionnaires were in this file. One was entitled "Your Opinion Counts" and the other "What the service user thinks." These gave people the opportunity to say what mattered to them about the services being provided.

People and relatives told us they had the opportunity to attend group meetings with the manager and other staff. We saw the minutes of the meetings for May 2016 and September 2016 where a number of topics were discussed; such as the carpets, menus, outings and administration processes. People told us they had been given the opportunity at the end of the meetings to ask questions and the responses recorded. People told us they had also just had a meeting and the manager told them they would receive a letter in the next couple of days with an update from the meeting. A suggestion box was near the manager's office and the people we spoke with were aware it was there, but had not felt the need to use it yet.

Staff told us they worked well as a team and felt supported by the manager, deputy manager and senior staff. One staff member said, "It's not brilliant at times, but we all work together otherwise I would not be here." Another staff member told us, "I'm always happy to come to work. Today I've had a good team on with me." Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meetings for March 2016 and July 2016. The meetings had a variety of topics which staff had discussed, such as care plans, accident recording and training. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. The minutes of the meeting showed staff were given time to express their views, with explanations given, if possible, or suggestions for moving forward. Staff were aware of the whistleblowing process and would not be worried about putting this to use if a need arose.

The manager and the deputy manager was seen walking around the home. They knew the names of all the people, relatives and visitors. They gave support to staff when asked and checked on people's needs.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not been involved in the formation of their care plans, which had not been updated and not adhered to by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken into consideration the complex needs of people who used the service and there were insufficient staff to meet people's needs.