Vishomil Limited

St Winifred's Nursing Home

Inspection report

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West Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 30 October and 1 November 2017. St Winifred's Nursing Home provides personal care and nursing care for up to 38 older people, some of whom are living with dementia. On the days we inspected there were 22 people living at the home.

The home did not have a registered manager in post at the time of inspection. 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.

We had previously inspected the home in April 2017 and rated the service as 'Inadequate' and in 'Special Measures'. At the inspection in April 2017, we found nine regulatory breaches which related to safe care and treatment, premises and equipment, staffing, safeguarding, consent, dignity and respect, person-centred care, complaints and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Overall we found some improvements had been made in the home since our last inspection, although there were still areas where further improvement was required. The provider remained in breach of six regulations. The provider was no longer in breach of regulations which related to safeguarding, consent and complaints.

Improvements had been made to assess and mitigate risks to people's health, safety and welfare. Unsafe equipment had been replaced. The provider had begun to replace the carpets and radiators. However some radiators remained hot to touch and the risk in relation to this had not been managed.

The systems and processes in place to manage medicines were not always safe or effective.

The provider had not assessed whether staffing levels were sufficient to meet people's needs in a timely manner. People told us they waited a long time for their call bell to be answered.

Staff recruitment checks were completed before new staff started work to ensure their suitability to work in the care service. Staff did not receive a robust induction.

The manager had begun to ensure staff received supervisions but had not begun to assess staff's competency.

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

Staff interaction was positive and supportive with people on the whole, although staff were on occasion task focused. When staff assisted people, they were kind and patient. However some people's continence needs were not always managed in a timely way. We observed people who needed support to mobilise sat in the residential unit lounge for long periods without moving.

All care records, except one, had been updated. We found care records were organised but were not always fully completed. Work had begun regarding the provider's approach to managing behaviours that challenge.

The provider had an up to date complaints policy displayed within the home. We saw complaints were logged, investigated and the outcome communicated to the individual.

Day to day leadership and management of the service had improved since the last inspection. Staff now felt supported and positive. Staff told us the service had got better. The quality assurance systems for assessing, monitoring and improving the quality of the service had improved but were in their infancy and there was insufficient time for these systems to become embedded. However, the provider did not effectively monitor or assess the service.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The systems and processes in place to manage medicines were not always safe or effective.

Staffing levels were not sufficient to meet people's needs in a timely manner.

Some improvements had been made to assess and mitigate risks to people's health, safety and welfare.

Is the service effective?

Inadequate

The service was not effective.

Arrangements were in place to ensure staff received regular supervision and training. However, there was not a robust induction programme in place.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to access a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff were kind and caring, although we saw occasions where care was task focused.

We saw an isolated incident where a person's dignity was not maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were accurate and up to date but some lacked detail.

Activities were limited, particularly during the morning.

Complaints were recorded and dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

Day to day leadership and management of the service had improved since the last inspection. However continued breaches of regulations were identified at this inspection. Staff felt supported by the manager and listened to.

Management quality assurance systems for assessing, monitoring and improving the quality of the service were in their infancy and there had been insufficient time for systems to become embedded.

Systems were not in place for the provider to maintain an overview of the safety and quality of the service.

St Winifred's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 30 October and 1 November 2017 and was unannounced.

The inspection on 30 October 2017 was carried out by two adult social care inspectors, a specialist advisor pharmacist 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. Their area of expertise is in relation to older people and dementia care. The inspection on 1 November 2017 was carried out by one adult social care inspector.

We reviewed information we held about the service, such as notifications, information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England. We also reviewed the 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.

During the inspection we spoke with five people who used the service and three people's relatives. We also spoke with six members of care staff, the cook, the maintenance person, the administrator, cleaning staff, the activity coordinator and the manager.

We looked at a variety of documentation including; care documentation for six people, two staff recruitment files, meeting minutes, documents relating to the management of medicines and quality monitoring records. We observed care practices and lunch time.

Inadequate

Is the service safe?

Our findings

At the last inspection we found there were not effective systems in place to assess, monitor and manage risks to people and keep them safe. We found the provider failed to maintain a clean/well maintained environment to minimise risk of infection. The systems and processes in place to manage medicines were not always safe or effective. We concluded these demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area, however the provider continued to be in breach of this regulation.

Care records were well organised and easy to follow. However we still found instances where risks were identified but there was a lack of guidance for staff to show how these could be minimised. For example, one person's care plan for breathing showed they were at high risk of aspiration but there was no risk assessment to guide staff what to do if this happened. The choking risk assessment was blank. However we saw evidence the person had been referred to the speech and language therapy team (SALT). In another person's care plan we saw a choking risk assessment and a care plan which identified how to minimise the risk of choking and when a referral to the SALT team should be made.

We saw one person had guidance in place regarding their skin integrity. This included the type of mattress and equipment they required and a repositioning chart. There was a risk assessment which showed the person was at 'very high' risk of pressure damage to their skin, but no clear guidance about the repositioning required. Staff were aware the person had high risk pressure areas. They told us the person needed to sit in their specialist chair at times and we saw they were supported to do so.

In another person's care plan the person was stated to have 'delayed or less effective cough reflex' and 'previous history of choking or gagging' yet we saw they had a bag of sweets within their reach. The person's capacity assessment around eating and drinking stated they could decide what they wanted to eat and drink. A risk assessment identified the person was at medium risk of choking, yet there was no guidance for staff about how to minimise or manage this risk.

We concluded the information above demonstrated there were not effective systems in place to assess, monitor and manage risks to people and keep them safe. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Where people needed support with their mobility we found the care records showed clearly what equipment they needed and how many staff would need to support. Where hoisting slings were needed there were details about how these should be used.

We saw people had Personal Emergency Evacuation Plans in their care records which had been updated with their recent room changes. However, these had not been updated in the fire evacuation file. We raised this with the manager and saw it had been completed on the second day of inspection.

People told us they felt safe living at St Winifred's. One person said, "I'm safe and there is no need for

complaints. I think I like it here." Another person told us, "I'm safe and very happy here." One relative commented, "I think it's safe and it has improved a lot lately since the new manager arrived."

The provider had employed an interim manager to improve the service. The manager told us, and records confirmed, upon coming into post they had disposed of condemned equipment, which included bedrails and hoists. Beds and bedrails had been replaced with profiling beds, with integral bedrails and full length protective bumpers which we saw in use.

Safety check records showed regular checks were made of lights, portable appliances, water temperatures, plumbing safety, fire equipment, window restrictors, wheelchairs, bedrails and commodes. The manager undertook more detailed audits of bedrails, with a list of the people who used them, the reasons why they were required and their consent. Records of lifting equipment checks were completed.

The maintenance staff told us they carried out all routine checks and maintenance of premises and equipment, unless this was something which required a specialist contractor to complete, such as hoists. They told us they tested the stability of the commodes by sitting on each one, although they were not aware of any manufacturer's guidance on how to test the safety of the commodes.

Regular checks were made of mattresses and lifting slings and we spoke with the member of staff responsible for this. They confidently described how they checked each mattress and each lifting sling and what might alert them to a fault. We saw a monthly log of each sling, who it was for and how it had been checked. The member of staff responsible told us each person who required hoisting had their own individual sling which was kept in their room and staff were aware to visually check all equipment before use.

Staff we spoke with said they were confident to use equipment with people who needed it and they said they had received appropriate training in moving and handling. We observed people were supported in the hoist safely and confidently with reassurance from staff. However, during lunch time we observed three people from the residential unit, had been left with their wheelchair footplates in place and the brake on one person's wheelchair had not been applied throughout the meal. This meant there was a risk people may topple their wheelchair if they tried to stand on the footplates and without a brake on, the wheelchair may move.

There had been one safeguarding incident regarding bedrails in September 2017, where the use of bedrails had not been safely assessed and the person had become entrapped. The person now had a safety wedge in place to remove this risk.

We found systems and processes in place to manage medicines were not always safe or effective. Staff signatures on the Medicine Administration Records (MARs) did not always indicate that the receipt of the medicines was witnessed. This meant the system in place to confirm the medicines received were correct was not robust. There was no description of the medicines on the blister packs from the pharmacy, and it was observed for one medicine there was a significant difference in the appearance of it in different sections of the blister packs. This had not been discussed with the pharmacist and therefore staff could not confirm the correct medication had been dispensed and received into the home.

Staff had signed to indicate they had read medicines policies and procedures. However, the new clinical lead had not signed to say they had read the policies and procedures and when questioned they were unaware of the ordering procedure for medicines within the home. This meant there was a risk that the correct procedure may not be followed and staff may not follow up to date guidance.

A monthly medicines audit was carried out by the manager and a communication diary informed staff of any issues identified and any changes to policies. The local clinical commissioning group had also carried out a recent audit but no report had been received at the time of the inspection. A meeting was also planned with the manager and the supplying pharmacist to organise regular input and audits to help improve medicines practice.

We identified several incidents of missing signatures on the MARs and the reasons for non-administration had not been recorded. These gaps had been highlighted by the manager indicating they had been identified but they had not been formally investigated to establish if the medicine had actually been given. There had also been an incorrect administration of a medicine for several doses. This had been rectified but there had not been an incident report which meant we could not be satisfied the provider had reviewed their systems and put appropriate measures in place to prevent incidents reoccurring.

Stock checks of both controlled drugs and stock medicines were correct at the time of the inspection. The provider's procedure was to check the stock of non-blister packed medicines each time they were administered. However we saw the amount administered was being deducted from the previous total instead of a physical stock check taking place. This meant any discrepancy in the stock levels would not be identified promptly.

Medicines, thickening agents and nutritional supplements were stored in locked trolleys or medicines cabinets within a dedicated clinical room. Keys were held securely. However creams, including medicated ones, were not routinely stored in locked cabinets within people's bedrooms which meant that medicines were not always held securely. The temperature of the clinical room and the lockable medicines fridge was recorded daily. The fridge records did not include the maximum and minimum temperatures and were not recorded at the same time each day. This meant the provider could not be confident the temperature of the fridge was safe to store medicines. Drug alerts were kept in the Nurse's office. Patient information leaflets for the medicines being taken by people were not available within the clinical room with the medicines. This meant that guidance for staff about the medicines people were taking was not easily accessible if people had any issues or questions about their medicines at the time of administration.

Controlled drugs (CDs) were stored within a standard medicines cabinet within the clinical room rather than a stand-alone controlled drugs cabinet. This was also being used to store money as well as the controlled drugs and the key was kept with the other medicine keys rather than separately. This meant that controlled drugs were not being stored in compliance with the Misuse of Drugs (Safe Custody) Regulations 1973. A register was used to record the receipt, administration, stock checks and disposal of controlled drugs. Entries in the CDs register were occasionally crossed out rather than using an asterisk and explanation being used to highlight the error. This meant there was a risk information regarding any changes to errors would be illegible.

People's MAR charts were kept in a folder with each medicine trolley. The folder also included information about different formulations, a signature list, a pain assessment chart and details of which person required their medicines at times outside the usual medicines rounds. Each person had a front sheet which included a photo and their allergy status. However, one person had had an allergic reaction to a patch but their allergy status still said 'none known' and it was not clear whether the allergy was to the drug or the patch glue. This was important as the person was now using a different patch. One person had an allergy to warfarin recorded on their MAR but not on their medicines front sheet which meant that allergy information was not available at all stages in the administration process. Another person had an allergy to ibuprofen recorded, but it did not state if this was just in relation to the tablet form. This person had an external gel preparation prescribed on a PRN 'when required' basis which contained ibuprofen, although it had not been

used. This meant there was a risk people did not receive medicines safely.

Handwritten amendments or entries on the MAR charts were witnessed by staff. However when a change was made to the dosage instruction, we saw the MAR chart was being amended on the original entry instead of a new entry being created so that the administration record would correspond with the prescribers instructions. Several medicines had not been administered from the blister packs but the charts had been signed to indicate that administration had taken place. Upon investigation there seemed to have been a crossover with the person's medicines on arrival and the delivery from the pharmacy but this had not been documented on the MAR as to why this had occurred.

For some of the PRN 'when required' medicines, there were clear protocols as to when and how to administer them. However it did not indicate when people had been offered their PRN medicines but not needed them. This meant it was not clear whether the prescriber's instructions were being followed. The PRN documentation was also being used to record information about regular medication which meant that there was a risk that information could be misinterpreted. Although some PRN medicines had been reviewed there was not a scheduled review of the 'when required' protocols and we saw some medicines were being given 'when required' even though the label indicated they should be administered on a regular basis.

We were informed no one received their medicines covertly. However, we identified one person whose PRN medicines were to be given covertly. It was therefore not clear whether staff would follow the correct processes to administer medicines covertly.

Body maps showed where creams should be applied and where there was more than one cream a colour coding system was used. However, we identified inconsistencies in the procedures for the administration and recording of these. Some people had medicated patches, recorded on the MAR chart, and a body chart indicated where they should be applied. However, the removal of medicated patches was not clearly recorded and for one brand of patch the body chart rotation did not ensure that it was applied as recommended by the manufacturer. This meant that there was a risk that old patches may not be removed before a new one is applied and that the patch would be applied too often to one area of the body.

One person was supported to self-administer their inhaler. A risk assessment was in place but there was no monitoring to ensure the correct use.

The nurse on duty wore their medicines administration tabard during the medicines round to prevent interruptions. However, they did not always remove it promptly once finished thus negating its purpose.

Medicines were disposed of using dedicated bins which were collected by the pharmacy. Disposal records were in place but were only signed by one member of staff. This meant there was not a robust system in place to confirm the disposal of medicines.

The issues identified above demonstrate the systems and processes in place to manage medicines were not always safe or effective. We concluded this is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

When we arrived and looked around the building we found the premises had some unpleasant odours. Once the member of cleaning staff had begun their work, areas were cleaned and odours were minimised. However, there continued to be a malodour in one room and there were some areas in need of a more thorough clean, such as underneath bath chairs. There were some dead insects in light fittings.

One member of cleaning staff described their cleaning regime. They used colour coded clothes to prevent the spread infection. They showed us the mop handle was red and this was used for bathroom floors. We were informed mop heads were not laundered after each use but were replaced on a weekly basis. This was not sufficient to control the spread of infection. There was an appropriate supply of personal protective equipment (PPE) in corridor areas and there were paper towels and liquid soap in the bathroom as well as anti-bacterial gel at strategic points in the home.

The member of staff responsible for laundry told us they knew how to minimise the risks of infection and said they made sure they did not transfer from the laundry to the dining / kitchen areas when carrying out their laundry work. There were organised systems for managing people's washing and there was an appropriate supply of PPE.

We saw evidence catheter bags were replaced. We saw one person's catheter bag was below their skirt, near to the floor. We spoke with the team leader regarding this. We were informed the person was irritated by the straps holding the bag in place. Other options had been considered as not suitable, although no referral had been made to a healthcare professional. We saw evidence the person on occasion completed their own catheter care to maintain their independence.

At the last inspection we found issues regarding varying water temperatures. We saw environmental risk assessments had been completed but found these did not cover some areas of risk we found during the inspection. We concluded these demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area, however the provider continued to be in breach of this regulation.

Some areas of risk identified at the previous inspection still existed. For example, we found the provider had taken some steps to ensuring people's safety with regard to radiators. Some radiators seen at the last inspection had been replaced. However, although some radiators had been replaced, we found not all radiators were a safe temperature to touch. Some radiators in the corridors were too hot to touch without burning. We discussed this with the manager who said they were negotiating with the provider about replacement radiators, for safety and heat efficiency in the home. We discussed radiator temperatures and room temperatures with the maintenance staff who told us the manager was in the process of trying to make sure all radiators were replaced. We found there were differing temperatures in the home and there were some areas much cooler than others.

We saw there was one corridor area where the carpet did not fully cover the gripper and the sharp tacks were exposed. The manager told us there was a phased plan to replace all the carpets. There was also a brass handrail in the corridor which had protruding fittings underneath which might be a possible injury hazard for people walking round the corridor. The manager told us they did not feel it was a hazard but would assess this. The manager stated that no one had ever come to any harm as a result of this fitting.

Some areas in the home needed attention. For example, there was some cracked glass in the door to one of the garden areas. On the residential side near the main front door there was a box on the wall with some wires exposed. The floor surface in one bathroom was in need of replacement. The garden was unkempt.

The issues identified above demonstrate that areas of risk still existed and had not been mitigated. We concluded this is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found there were no areas where water was too hot, although in two communal sinks in two bathrooms,

the hot water was too cold. The manager said they would arrange for the maintenance staff to attend to this.

Window restrictors were now in place and regularly checked. None of the windows we looked at could be opened fully.

We saw the provider had refurbished the kitchenette and replaced some carpets in corridors. Staff told us this was much improved and had made the home brighter and lighter.

At the last inspection we found there were insufficient numbers of staff to meet people's needs. Call bells were not responded to promptly and for periods of time staff were not available in the communal areas. We concluded this demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area, however the provider continued to be in breach of this regulation.

Since the last inspection the provider had separated the home into a residential and nursing unit and had increased the levels of cleaning staff. There were two care assistants on each side of the home and a fifth member of staff who was supporting care in the morning and doing laundry in the afternoon. There was a registered nurse, a cook, kitchen assistant, a cleaner, the maintenance person and the activities coordinator.

All the staff we spoke with told us there were enough staff to meet people's needs. Although staff said when two of them were attending to one person, others had to wait, although not for long.

The provider remained without a system to audit call bell response times. They stated they were waiting for an Information Technology (IT) company to install the computer software to enable this to be done. A dependency tool was used for each person but there was no management overview to ensure staffing levels were appropriate. The manager was confident staffing levels were sufficient as the staffing levels had remained the same although the number of people within the home had decreased.

One person told us, "I think there are enough staff. I have a buzzer, which is always on this table, whether it's near my bed or in this room. When I press my buzzer, the staff tend to come when they can. They're not always very quick." Another person said, "They don't always come quickly when I ring for help." A third person commented, "It seems to take them a long time to answer the buzzer. I am always wet through by lunchtime because they don't come to answer -my call on the buzzer."

One relative said, "I have noticed that they are slow to respond to the buzzer, although at least since June they are turning up at some point, so that's an improvement." Another relative told us, "The staff are OK, but they do need more carers. It takes a long time before anyone is free to support my [Relative] when [they] need it."

A member of the inspection team waited more than five minutes for a member of staff to respond to a buzzer they had asked a person who lived at the home to press.

We saw people were unattended in lounge areas at times. For example, on the nursing unit there was one person in the lounge with the television on at 9am. There was no staff presence for the 40 minutes an inspector was in the room. We spoke with the staff who explained people had turning regimes which took their time and all of the 10 nursing residents required 2:1 support. In the residential unit we observed there were no visible members of staff from 12.35pm to 12.45pm.

We observed an incident which impacted on a person's dignity. We could not locate a member of staff for 10 minutes which led to the person being incontinent.
The issues identified above demonstrate there were insufficient numbers of staff to meet people's needs. We concluded this demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection staff were not aware of external organisations they could report safeguarding matters to. Staff did not always recognise when to make safeguarding referrals. We concluded this demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found improvements had been made in this area. The provider was no longer in breach of this regulation.

Staff were confident in how to safeguard people from abuse and said they would always report any concerns without delay, to the manager or the safeguarding authority if necessary. Staff said they would always report poor practice if they saw this in the home. Staff told us they had received safeguarding training and records confirmed this. We saw appropriate safeguarding referrals had been made to the local authority.

We looked at staff recruitment records and found staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. Although the checks had been completed one person's reference and Nursing and Midwifery Council (NMC) pin check was not in the files. These were found during inspection and placed within the recruitment files. We found there were no copies of interview notes. The manager told us they would ensure this was done in the future.

Inadequate

Is the service effective?

Our findings

At the last inspection we found some management observations of staff practice did not evidence a robust approach to ensuring staff remained competent in their role. There was no evidence the observations were signed by staff or reviewed by the manager. We concluded this demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found the provider had not addressed this area and continued to be in breach of this regulation.

The manager told us staff observations and competency checks had not yet commenced as they wished to ensure staff were sufficiently trained and confident in their roles before observations took place. This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw one member of staff had completed an induction but this had not been signed off by a supervisor to confirm their competency. Another member of staff did not have any information within their staff file regarding an induction. We saw evidence to show this member of staff had shadowed a 12 hour shift before working on their own. The manager said they were in the process of improving the induction. They told us new staff did shadow experienced staff, but there was no documentation clearly regarding what was expected of them and the topics they would cover. The provider was not satisfying themselves that staff were competent in their role. This is a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff we spoke with said they had plenty of opportunities for training and they felt supported in their role. They said they had regular supervision and thought the new manager was very supportive and approachable. Staff told us communication was effective and they had handover meetings and used the communications book in the office to note key points.

A training matrix was in place. There was a member of staff responsible for reminding staff to complete training. We saw posters in the office reminding staff when training was due. We also saw a continence care training session had been arranged for November 2017.

The manager told us they were aware of gaps in training and were in the process of arranging staff training. We noted the online training certificates in people's staff files gave a percentage pass mark which was converted into a grade. The member of staff responsible for training was unsure about what was done with the information. They believed staff only had a certificate generated when they passed the course. If they did not pass, the course was repeated. The manager told us if staff passed a course but with a low score no further development took place, although this was to be reviewed. Neither the manager nor the member of staff responsible for the training knew the percentage pass marks for each course.

A supervision matrix was in place and staff had begun to receive supervisions. We saw where supervisions had taken place they were positive and ensured staff were praised for the good work they had done. Supervisions also addressed any areas that required improvement such as where documentation had not

been completed to the appropriate standard. The manager was aware not everyone had received a recent supervision and they informed us they were in the process of delegating line management responsibility for this to the clinical lead, team leader and seniors. We spoke with the team leader who showed us the personal development plans of the senior members of staff to show the supervisions and support they were being given prior to being delegated line management responsibility.

At the last inspection staff lacked understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). MCA assessments were not decision specific and there were no capacity assessments for bed rails and sensor mats. We found contradictory information regarding people's capacity. We concluded this demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found improvements had been made in this area. The provider was no longer in breach of this regulation.

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

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

One person told us, "I don't think that I have a say in my care. The staff just get on and do it. I don't know what a care plan is and I haven't seen one." Another person said, "The staff here are OK and I'm happy with everything – you have to be, don't you? I don't think I've seen a care plan." One person commented, "Staff usually ask me if it's all right before providing care. I have not seen my care plan." Another said, "The staff normally ask before they provide care to me and I have seen my care plan."

Staff were knowledgeable about the MCA. They explained how they supported people to make decisions about their care. For example, they showed people a choice of clothes. Throughout the inspection we observed staff respecting people's choices including, when to get up and have their breakfast.

We found appropriate action was taken when people lacked capacity to make decisions. The registered manager was knowledgeable regarding how to conduct 'best interest' meetings and when to make DoLs applications. We saw in one person's care plan there was evidence of a two stage mental capacity assessment for each decision made. Where the person was assessed as having capacity to consent about bedrails, but they were unable to verbalise this, staff had signed along with a staff witness signature.

We saw there were risk assessments in place for bed rails with a checklist to show other less restrictive alternatives had been considered and this had been discussed with the person or their representative.

There was a checklist in place to monitor when DoLS applications had been made to the supervisory body (the local authority), when any applications had been authorised, whether there were any conditions and when the authorised DoLS were due to expire. The checklist was recently put in place and the team leader was in the process of ensuring the conditions were being met.

People told us they had access to other healthcare professionals, including GPs, when required. One person said, "Lots of people come to look after me. For example, the GP, optician, chiropodist and dentist." Another person told us, "I am visited by my GP, the optician and the local dentist has visited once." One relative said,

"The local dentist comes to visit and the GP has been occasionally."

There were details in people's care files of other professionals associated with their care, such as district nurses, speech and language therapists, chiropodists and opticians. One person's care record stated they should wear glasses. We saw there was a recent prescription for new bifocals. We saw the person was wearing these to read and watch television, in line with their care plan.

People told us they had a choice of food. One person told us, "I have had cornflakes and toast for breakfast. I could have other food, but I like this best at breakfast." We saw staff offered people choices of breakfast and drinks. Staff gave people a visual choice of whether to have juice or water. We heard one member of staff asked a person, "Do you want your bath first or your breakfast?"

We observed lunchtime and found both the TV and cassette player were on in the dining room. There was loud music playing war songs, often with air raid sirens. This was distracting to people who used the service and we saw there was minimal conversation between people during the meal.

We observed staff asked people whether they would like to wear a clothes protector during the meal. People had to wait a length of time before their meal was served. People were observed to be falling asleep. One person was repeatedly shouting, "Where's my food? I want my food. Where's my food?"

We observed one person had not eaten much of their pork lunch. We mentioned this to a member of care staff who exchanged the pork for the cottage pie option which the person ate. It was not evident that staff would have done this had we not brought it to their attention. We saw the manager bringing another service user some more gravy when they requested this.

We spoke with the cook who said there were improved menus and they considered people's nutritional and hydration needs were met well. The cook told us they were aware of people's dietary needs and they prepared the pureed meals as well as fortifying food with additional calories for those people at risk of weight loss. They told us there were some people who needed a diabetic diet and they made sure there were reduced sugar provisions for those people.

We considered the design and layout of the premises was not dementia friendly. Some of the carpets and wallpaper were patterned which would be disorientating for a person with dementia. There was no pictorial labelling, or signage to help people navigate to the toilets or to their rooms.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we saw isolated incidents where staff were not caring or considerate. Our review of records showed people frequently went for periods of up to three weeks without having a bath or shower. We concluded this demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area. However, we found evidence to demonstrate the provider continued to breach this regulation.

We observed an incident which impacted on a person's dignity. One person wanted to go to the toilet. This person was usually independent with their toileting needs but on this occasion they were unable to access the toilet independently. We could not locate a member of staff until ten minutes later. This led to the person being incontinent. We observed people in the residential unit lounge sat for long periods without moving. This demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "The staff are patient and kind. They usually treat me with respect and they listen to me" Another person said, "All the staff are OK. I get on well with all of them. Some do knock at the door before they come in and some don't. I think they would listen to me." One person commented, "Yes, the staff know me and they understand my needs. They sometimes listen and sometimes act on what I say. They do respect privacy in that they always knock at my door before coming in. I don't believe I have any independence here. They never encourage any mobility here. They should do, you know. It is in my care plan."

The person's relative said, "[My relative] seems to be understood here, but I think that mobility could be better supported. I really think they can be too cautious."

One relative told us, "They're kind and caring here and my [relative] gets the right kind of support when [they] need it and [they are] treated with dignity and respect, at least when I am here. [Their] quality of life is better in here than it would have otherwise been at home. They do try as far as possible to support independence skills and [their] mobility is being supported."

Staff told us they respected people's wishes and explained what they were doing. Staff told us people's religious needs were met and a priest and vicar visited the home. Staff explained they encouraged people to be independent. For example, they could wash their hands and face or if food was cut up people were able to feed themselves. Staff said they encouraged people to select their own clothes and be involved in putting their clothes on.

Staff interaction was positive and supportive with people on the whole, although staff were on occasion task focused. For example, we observed one person being supported in their room with their meal one to one, and the member of staff did not speak with them. However, another person was supported in their room and the member of staff chatted throughout, offering conversation and a running commentary about their meal, what they were having and whether they enjoyed it.

When staff assisted people, they were kind and patient. We saw staff reminded people to use their walking aids if they needed these. For example, one person who liked to walk up and down the corridor needed two sticks to walk with and we heard staff remind them to take their 'sticks' with them. Staff knocked on people's doors and waited before entering and they made sure people's bedroom doors were closed when managing personal care.

At this inspection we found there was no evidence people went for long periods without having a bath or shower. Staff confirmed people were able to have a bath or shower when they wished. We saw people were appropriately dressed and presented well.

Care records showed some end of life wishes had been discussed in the 'death, dying and spirituality' section. Care records showed how staff should respect people's individual preferences for their personal appearance.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found care records were not up to date and accurate. We saw the provider did not have a robust approach to managing behaviours that challenge. Activity records we reviewed showed there were few meaningful activities taking place for some people. We concluded this demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area, however the provider continued to be in breach of this regulation.

All care records were in the process of being re-written to ensure they met people's needs. We found care records were organised but were not always fully completed. For example, two people's 'getting to know you' booklets were not completed. Care plans such as for Parkinson's and hypertension gave general guidance about the health condition and were not specific to the person. This demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person's care record stated they should wear glasses. We saw there was a recent prescription for new bifocals. We saw the person was wearing these to read and watch television, in line with their care plan. In another person's care plan we saw it clearly stated what the person could do for themselves and what they liked to eat and drink.

We saw care records were reviewed on a regular basis. During one review we saw changes had been made to the person's care plan to ensure it included guidance for staff to complete Antecedents, Behaviour and Consequence (ABC) charts if a person became distressed when offering personal care. ABC charts are used to record behavioural concerns. These can then be reviewed for patterns, trends and triggers.

The manager had begun to address the approach to managing behaviours that challenge. We saw ABC charts were completed and these were reviewed on an individual basis. We saw when monthly care plan evaluations took place the ABC charts were reviewed. ' X has had 10 episodes of challenging behaviour. All episodes are at the point of delivering care.' We looked at this person's care plan and it guided staff how to minimise the risk of challenging behaviour. The plan stated that full explanation should be given to the person before care interventions were carried out. It outlined the behaviours the person might display and how staff should respond.

One person told us, "I like knitting, but I don't really like to do the singing and the other things here. I used to go to the Baptist church and it would be nice to have some contact with them." Another person said, "I am visited by the vicar of [church], once the month for holy communion. I really enjoy [their] visits because [they] always have a happy story for me and cheers me up no end." This person also commented, "I have suggested that we should try to get out into the fresh air, perhaps just sitting in the garden. That hasn't happened for over a year. I honestly think that we're treated like three-year olds. The reminiscence activity is all right though." One person said, "I don't do any activities with the other residents here." One person told us they were going singing and they enjoyed this. They had chosen what sandwiches to take out with them. One relative said, "There seem to be lots of activities during the afternoon, such as ping pong, bingo, sing-

songs, dancing, throwing soft balls into a net and so on."

We spoke with the activities coordinator who said she tried to get to know people's likes and dislikes and was considering new ways to engage people. Staff we spoke with knew people's individual backgrounds and social histories and it was evident from discussion they knew people well. Staff told us they had been at the home a long time and this had helped them understand people's needs. Staff told us people always had things to do on an afternoon but it was more difficult on a morning because they were busy assisting people. One member of staff commented people did not have any day trips out organised by the home. We found there was little meaningful activity taking place, although there was a group activity in the lounge during the afternoon.

At the last inspection it was not clear whether people's diabetes was being monitored appropriately. Staff were now clear the district nurses managed the diabetes monitoring for two people who lived in the home. This meant staff did not monitor people's blood sugar levels and the monitoring records were completed by the district nursing team.

At the last inspection we found the complaints procedure displayed in the home was not the same as the procedure provided to inspectors and there was no evidence to show complaints had been investigated. We concluded these demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found improvements had been made in this area. The provider was no longer in breach of this regulation.

The provider had an up to date complaints policy displayed within the home. We saw complaints were logged, investigated and the outcome communicated to the individual. There was a suggestions and feedback box available for people to use if they wished to provide information anonymously.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the management team did not have a visible presence within the home. Appropriate action had not been taken to ensure people were safe. The issues identified on inspection had not been recognised by the provider. Not all accidents and incidents were recorded. Accidents and incidents were not analysed. We found the provider audits were not sufficiently robust. The call bell system was not set up to monitor response times. The manager had not investigated any issues raised through surveys/feedback. We concluded this demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made in this area, however the provider continued to be in breach of this regulation.

The service did not have a registered manager at the time of the inspection. The registered manager had deregistered in August 2017. The provider had employed an interim manager to address all the issues raised at the last inspection. The manager acknowledged the amount of work required to ensure the home met sufficient standards. We found there was no evidence to demonstrate the provider carried out audits to ensure they were assessing and monitoring the quality of the service. The provider was not ensuring sufficient improvements were being made and continued to be made within the home. It was unclear as to the oversight the provider had of the running of the home. The manager stated the provider audits would commence in January 2018 and they were in the process of designing the audit.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found the provider had started to take some action to keep people safe. For example, new beds and bedrails were in place. The environmental action plan had intended completion dates and completion dates for the work required. The manager told us this was constantly being reviewed and they were confident work was in progress, with evidence seen of work carried out, but acknowledgement where work remained to be done. However some radiators in the corridor were still too hot and we found nothing had been put in place to mitigate the risk until they were replaced.

We found accident and incidents had been recorded. However, there continued to be no analysis of the information to identify trends or themes or look at 'lessons learnt' to prevent recurrences. The manager believed they had done this but accepted they could not provide evidence.

The call bell system still was not set up to monitor response times. We were not provided with a date when this would happen. There were no interim measures in place to ensure call bells were being responded to in a timely manner. There were no methods in place to determine whether there were sufficient staff to meet people's needs.

These issues demonstrate a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A staff survey had been completed and had been analysed by the local authority. The local authority had identified themes such as staff wanting to have more supervision and training. Although we saw the manager was addressing these areas, there was no clear action plan created by the provider in response to the staff survey. A survey had not been introduced for people at the home or their relatives to provide feedback on the service. However, a 'resident and relatives' meeting had taken place in September 2017 and the manager said they would take place every two months. We saw the CQC report had been discussed with staff and how the service could be improved.

We saw evidence to show staff were consulted and could input into the running of the service. We saw staff meetings were held. Where issues were highlighted through audits and spot checks these were discussed at the meetings. For example, the repositioning charts had been audited and this identified they were not always completed. The manager also raised issues they had seen when they carried out spot checks. For example, poor infection control practice, although the spot checks had not been recorded separately.

A weekly document audit was carried out by the team leader looking at four people's care. At present, due to the low number of people living at the home, everyone had their care audited every six weeks. The audit comprised of the person's care record and daily file which included; daily intervention charts, repositioning charts, personal hygiene charts and topical MARs. The audit highlighted any issues such as where documentation was not completed correctly. We saw any issues identified were followed up. For example, staff received supervisions which explained the importance of completing documentation and the consequences to the individual if it was not completed correctly. The weekly audits were signed off by the manager.

We saw monthly clinical audits were completed for equipment, pressure sores and people's weights. These were signed by the manager once they had seen them. We saw three people at risk of malnutrition who had been referred to a dietician. Their dietary input was monitored and they were weighed weekly.

Although audits had begun to take place, the manager acknowledged the governance systems were in their infancy. The governance systems were not fully embedded in practice. We found the CQC had not been notified of the granting of DoLS applications. This was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents. The interim manager retrospectively submitted the notifications and put a system in place to prevent this situation happening again. We also identified an oversight where one safeguarding incident had not been notified to the CQC, although it had been notified to the local authority and all other safeguarding concerns had been reported to CQC. The manager was not sure how this had been overlooked.

People were complimentary about the manager of the service and told us they were approachable. Comments included: "I've met [manager]. [They are] very nice to speak to and [they] listen to us. The staff are friendlier now.", "I really like the new manager – [they're] lovely. If I want anything I can ask [them]. [They are] so pleasant."

One relative told us, "It's a much improved service since [the manager] arrived. I find [the manager] to be approachable. The staff morale seems to have improved considerably too. It's interesting that [my relative] thinks that the staff are friendlier. I think that's true. People greet you now when you come in and that didn't happen before." Another relative said they had noticed "significant changes" in the way the service was run. They said the manager was visible and present and took an interest in the people who lived at St Winifred's. They told us they had seen changes in the environment and improvements in the quality of care. They told us they felt all staff were approachable and knew their family member well; they felt welcome to visit at any time and well informed about their family member's care.

Staff were very positive about the new manager and were confident improvements were being made to the service. One member of staff said, "This home has massively changed since the manager came. They get things done, unlike previous managers." Another member of staff said, "Since [the manager]. It's been fabulous. I can't wait to get to work." Staff said the new manager gave them autonomy to suggest ways in which the home could improve and asked for 'solutions, not just problems'. Staff said this made them feel welcomed and valued. Staff told us they felt listened to. A member of staff said, "I feel appreciated. I'm asked for ideas." Another said, "It has brought us closer together. I recognise good practice and I'm given praise."

Staff said communication was good, as was staff morale because they had confidence the manager was able to bring the home up to standards. The staff we spoke with said care would be good enough for a relative of theirs.

Following inspection, the CQC were sent provider reports which were carried out in September, October and December 2017. The reports demonstrated that the audits carried out by the provider were not sufficiently robust. The provider did not have effective systems or processes established or operated to assess, monitor and improve the quality and safety of the service. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service. The provider audits did not review any care documentation, risk assessments or staff files. The audits lacked detail and did not include action plans. The provider had not identified any of the issues found at inspection. For example, the home remained without a system to audit call bell response times; accidents and incidents had not been analysed and relevant notifications had not been submitted to the CQC. The provider had not identified there was no evidence to demonstrate thorough inductions were taking place. In one audit the provider recognised the on-going repair of radiators but failed to put interim measures or to undertake a risk assessment to ensure people were safe. The provider audits did not seek any views of the people who used the service.