

London Residential Healthcare Limited

Oaklands House Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

During an unannounced comprehensive inspection at Oakland's House Care Centre on the 29 and 30 June 2015 we found a number of breaches of the legal requirements and as a result we took enforcement action. We served two warning notices on the registered provider requiring them to make improvements to the governance arrangements in place and the safety of care and treatment people received. The improvements had to be made by 28 October 2015. We also found that improvements were required in relation to the staffing levels, staff training and supervision, how the Mental

Capacity Act was applied, the provision of person centred care and how the service notified the Care Quality Commission (CQC) of significant events within the service. The provider sent us an action plan which told us how they intended to make improvements in these areas. On the 23 and 25 November 2015, we undertook a focused inspection to see whether the required improvements had been made. You can read a summary of our findings from this inspection below.

Summary of findings

Oakland's House is registered to provide accommodation and nursing care for up to 54 older people who may be living with dementia and / or have a physical disability. On the day of our visit 48 people were living at the home. The home is located in a semi rural location on the outskirts of Southampton, near the village of West End. The home has two large living rooms / dining areas. People's private rooms are on both the ground and first floors. Four of these rooms are shared. There is a passenger lift to the first floor. Outdoors there is a secure patio area.

The provider has recently completed building a 26 bed extension and has submitted an application to the CQC to register these additional beds. This application is currently being considered by the CQC.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager was appointed in July 2015. They have submitted an application to be appointed as registered manager. This application is currently being considered by the CQC

We found that the registered provider and new manager had taken action to make some improvements, but further improvements were still required.

Further work was needed to ensure that the Mental Capacity Act (MCA) 2005 and its Code of Practice were used effectively and consistently within the service. Staff had not completed all of the training relevant to their role and were not receiving regular supervision.

We continued to find some examples of unexplained bruising or skin damage. We could not be confident that each of these had been adequately investigated to

ensure that the risk of similar incidents happening again had been addressed. The planning and delivery of care was still not always being managed in a way which mitigated risks to the health and welfare of people.

Further improvements were needed to ensure that each person had an detailed care plan which helped staff to deliver care to meet their assessed needs.

Improvements had been made to the quality assurance systems were in place, but these were not yet being fully effective and driving improvements.

Staff had been more effectively deployed to help ensure that people did not have to wait for support or assistance. Our observations indicated that people's needs were met in a timely manner and they were, for example, supported to eat and drink in a timely and dignified manner.

People's medicines were being managed safely. Medicines were stored in line with recommended temperatures. People were receiving their medicines as prescribed and accurate records were being maintained when medicines were administered.

Improvements had been made to the way the service was run and managed. The manager had taken action to ensure that the CQC were notified without delay of allegations of abuse.

This report only covers our findings of the inspection on 23 and 25 November 2015. You can read the report from our previous inspections by selecting the 'all reports' link for 'Oakland's House Care Centre' on our website at www.cqc.org.uk.

We could not improve the overall rating for this service because; despite identifying some improvements, some areas needed to improve further and we also identified continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will review the overall rating of requires improvement at the next comprehensive inspection where we will look at all aspects of the service and how the improvements have been sustained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Action had been taken to improve how safe the service was, however, further improvements were still needed.

The planning and delivery of care was not always being managed in a way which mitigated risks to the health and welfare of people.

There were suitable numbers of staff deployed to meet people's needs.

Requires improvement



Is the service effective?

The service was not always effective

The Mental Capacity Act (MCA) 2005 and its Code of Practice were not being used effectively and consistently within the service.

The training and supervision arrangements needed to be further embedded to ensure that they were being effective.

Requires improvement



Is the service responsive?

The service was not always responsive.

People's care plans and records needed to contain more detailed information about how their needs should be met.

Requires improvement



Is the service well-led?

Actions had been taken to improve how well led the service was, however, further improvements were still needed.

Further progress was needed to ensure that the improvements made were embedded and sustained so that a fully effective quality monitoring system was developed.

Key tools for sharing skills and knowledge, best practice and monitoring risks to people's health and wellbeing were being more effectively used.

Action had been taken to ensure that the Care Quality Commission were notified without delay of allegations of abuse.

Requires improvement



Oaklands House 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. The inspection checked whether the registered provider had made the necessary improvements following our comprehensive inspection in June 2015. The inspection considered whether it was appropriate to revise the rating for the service under the Care Act 2014.

The inspection took place on the 23 and 25 November 2015 and was unannounced.

On the first day, the inspection team consisted of one inspector and a specialist nurse advisor in the care of frail older people living with dementia. On the second day, there was one inspector.

Prior to the inspection we reviewed key information about the service. This included the provider's action plan, previous inspection reports and notifications received by

the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with six people who used the service and three relatives. We spoke with the manager, the dementia services manager, two registered nurses and five care workers. We reviewed the care records of 10 people in detail. We also reviewed the Medicines Administration Record (MAR) for each person using the service. Other records relating the management of the service such as training records, staff records, incident and accident forms, staff rotas and quality assurance documents were also viewed. During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot talk with us. We spent time in the communal areas observing how staff interacted with, and supported people.

The last full inspection of this service was in June 2015 where concerns were found in a number of areas.

Is the service safe?

Our findings

At our last inspection in June 2015, we found that the service was in breach of the Regulation which requires providers to ensure that people receive safe care and treatment. As a result we issued a warning notice requiring the provider to have made improvements by 28 October 2015. This inspection found that some improvements had been made. Staffing levels had improved and people's medicines were being managed safely. However, we identified that further improvements were needed to ensure that there were always adequate measures were in place to mitigate risks to people and protect them from harm.

We found a small number of new examples of unexplained bruising, skin flaps and other injuries that had not been adequately investigated to ensure that the risk of their recurrence was minimised. The skin damage had been treated appropriately until they healed, but there was no evidence to demonstrate that the possible cause of these had been investigated.

We were concerned that one person was mobilising independently without a walking aid of any sort. They looked very unsteady. We looked at their falls risk assessment. This had assessed the person as being at high risk of falls. Their falls care plan said 'I am able to move with use of either walking trolley or wheelchair'. We did not observe any staff reminding this person to use their walking aids or supervising their mobility. We were concerned that this person was at risk of harm.

At our inspection in June 2015, we found that the provider had not ensured that risks at service level were adequately identified and planned for. For example, we had noted that the 'Emergency fire box' located at reception had not contained all of the appropriate information. At this inspection some improvements had been made. Action had been taken to ensure that the contact details for key staff were correct. The box now included a detailed map of the building which identified where people's bedrooms were and drew attention to the fact that oxygen was stored on the premises. We did find however that the emergency fire box only contained six personal emergency evacuation plans (PEEPS). These are important as they provide key information about each person which supports the safe

evacuation of the premises in the event of a fire for example. We spoke with the manager about this; they took immediate action to ensure that a PEEP for each person was added to the emergency box.

The warning notice issued to the provider following our inspection in June 2015 had cited concerns about the lack of risk assessments in relation to infection control or the effective control of legionella and that a number of sash style windows on the first floor had not been sufficiently restricted to ensure that these did not present a risk of people falling from a height. At this inspection we found some improvements had been made. A legionella risk assessment had been undertaken in September 2015. A risk assessment in relation to Oxygen being stored on the premises was in place. An infection control audit had been undertaken in July and many of the recommendations from this had been completed or were underway. However, six of the sash style windows had still not been restricted to ensure that these did not present a risk of service users falling from a height. We were told that this was because they were awaiting parts. These windows have now been restricted. At the time of the inspection, the manager was not able to demonstrate that actions resulting from a fire risk assessment completed 21 October 2015 had all been completed. They have since the inspection sent evidence that demonstrates that these have now been actioned. A further fire risk assessment is planned for December 2015.

Overall we found that whilst a number of improvements had been made, some elements of the warning notice had not been fully met. Many of the improvements made needed to be more embedded to ensure they were being fully effective. We will undertake another inspection of this service to check whether the improvements have been sustained. If concerns remain, we will consider further enforcement action.

We found that the main open plan lounge/dining area was sometimes cold and people told us that they were cold. On the first day of our visit two of the people sat in the larger lounge were saying they were cold. Staff brought them and others blankets. The temperature in the lounge had been recorded as being 18C. This is the minimum temperature that the Department of Health recommends areas occupied by the elderly should be heated to. We spoke with a carer about the temperature in the lounge. They told us "it is the storage heaters they are not really very efficient but in the afternoon it gets really hot in here".

Is the service safe?

We recommend that the provider ensure it is providing sufficient heat to communal areas at all times in line with department of health guidance.

Some improvements had been made. People told us they felt safe living at Oakland's House Care Centre. One person said, "I feel very safe here". A visiting health and social care professional told us that they felt people were now safe. They said, "We used to have concerns every day, people being fed late, or got up late, they have employed more staff and we are now not getting any concerns". When walking around the home at the beginning of this inspection, we found that those that were able to use their call bells did have these in reach and so would have been able to summon assistance.

Staff were being more effectively deployed to help ensure that people were adequately supervised and did not have to wait for support or assistance. All but one of the people we spoke with told us there was sufficient staff to meet their needs. One person told us, "yes they usually come quickly...there is always someone to help me". Another person said, "Staff come fairly quickly, quickly enough for me". The manager told us staff had now been arranged into teams who were allocated to specific areas of the home and assigned particular people to care for each day. They told us that this had resulted in real improvements with the staff team developing a greater understanding and knowledge of the people they supported and taking ownership for this. A relative told us, "Since the staff have been organised into teams, things have been much better, you don't have to ask twice, they are more organised". A staff member told us, "We have plenty of staff here to ensure we can do what people need and that helps a lot, I think this is a great home". Our observations indicated that people's needs were met in a timely manner. Staff did not leave the communal areas unattended and so were available to assist people as necessary. We observed the lunch time meal and overall we found that people received the help they required in a timely and person centred manner. The mealtime experience, felt less hectic. We were no longer concerned that people might be overlooked and not receive their meal.

The current target staffing levels during the day were two registered nurses and nine care workers overseen and supported on weekdays by the manager and the dementia services manager who were also both registered nurses. These target staffing levels were based upon the

dependency needs of the people using the service and we were able to see that these were being reassessed on a regular basis. Rotas showed that the target staffing levels had been met throughout November 2015. The provider also employed dedicated cleaning, laundry, kitchen, maintenance, reception and activities staff.

During our inspection in June 2015, we identified concerns about how people's medicines were stored and administered. At this inspection, we found that most of the required improvements had been made. People told us they were happy with the way their medicines were managed. One person said, "They manage my medicines well, they ensure my pain is managed, they get me [my medicine] on demand". Another person told us that the nurses managed their insulin well and took their blood sugars every day.

A new treatment room was now in place to which only designated staff had access. Medicines were stored in locked trolleys and cupboards. Medicines requiring refrigeration were now kept in a locked fridge. The temperature of the treatment room and the refrigerator was recorded daily and demonstrated that people's medicines were now being stored within the recommended temperature ranges. Oxygen was now being stored safely, away from heat sources, and in line with relevant guidance.

We observed the nurse undertaking the medicines administration round. This was completed in a timely manner. The nurse approached people in a professional and caring manner and they explained to people what their medicines was for and where able, they asked for the person's consent or agreement before administering the medicine. The nurse waited to ensure that the person had taken their medicine before leaving. The nurse did not rush people and seemed to have a good rapport with them.

At our previous inspection in June 2015, we had found a number of examples where there was a gap in the person's medication administration record (MAR) but no code had been used to indicate the reason why. Records suggested that people were also not always getting their medicines as prescribed as these were for example, out of stock. At this inspection we found that the MARs were complete and up to date. We found that there was an efficient system in place to order medicines and this also helped to ensure that the service was no overstocked in any particular medicine. We also found that improvements were

Is the service safe?

underway to ensure that where people had 'variable dose' or 'if required' (PRN) medicines, that there was sufficient guidance in place for staff about when these should be given. We did find that some topical cream administration records (TMAR) still lacked detail about how often the creams should be applied and this is still an area which requires improvement.

National Institute for Health and Care Excellence (NICE) Managing medicines in Care home guidance states designated staff should administer medicines only when they have had the necessary training and are assessed as competent. Most of the registered nurses had received training in the administration of medicines in August delivered by a local pharmacy. A further session was planned for December during which the newly recruited nurses would receive this training. The dementia services manager told us that staff's competence to administer medicines was now being assessed every six months or when medicines errors occurred.

A record was being kept of incidents and accidents within the home and each month the manager undertook a review of the type, nature and number of each type of incident. This is important as it helps to ensure that appropriate actions are being taken to reduce the risk of further occurrences and helps to identify any trends of patterns which might be developing. For example, we saw that there had been 11 falls in November, following which two people had been referred for a review by their GP and two people had been referred for a physiotherapy review. Following a fall involving a recliner chair, the chair had been removed from use so that its safety could be reviewed.

Some improvements had been made. We have therefore revised the rating for 'is the service safe' from 'inadequate' to 'requires improvement'. We will check that further improvements have been made during our next planned comprehensive inspection.

Is the service effective?

Our findings

At our inspection in June 2015, we found that staff did not have all of the training relevant to their role. New staff were not always provided with a robust induction and supervision was not taking place on regular basis. We issued a requirement. The provider sent us an action plan which explained how they were going to address the concerns. At this inspection we found that some improvements had been made.

All of the people we spoke with and their relatives felt that the staff were well trained. One relative said, "I think they do a brilliant job, they seem to know what they are doing". We saw staff supporting people consistently using appropriate skills and behaviours. We observed staff completing a range of manual handling procedures competently and with care and attention. Staff told us that they undertook a range of training. One care worker told us, "I have had training in the Mental Capacity Act, dignity and safeguarding. In fact I have had a huge amount of training and it is all really useful". We asked a second care worker about the care and support required by a person whose records we were reviewing. The care workers said, "All of the instructions about a residents care is in their rooms so that we know exactly what to do". They were able to tell us about how the person needed their drinks prepared. The care workers knowledge was up to date and was in line with the information we had found in the person's care records. A health care professional who had previously told us that they felt some staff lacked skills and knowledge, explained that this had now improved. They said, "It's much, much better, the home seems to have turned around". They told us how staff had also recently provided some end of life care to a person really skilfully.

Whilst people told us that the staff team was well trained, we found some staff had still not completed all of the training relevant to their role and this is an area which requires improvement. For example, our last inspection report had raised concerns about the small number of staff trained in caring for people living with dementia and in managing behaviour which can challenge. This was still an area of concern. The manager explained there had been a delay in the provision of formal training in these areas whilst new staff were recruited. They said that in lieu of this, they and the dementia services manager, who is based full time at the home, had over the last four months spent a lot

of time coaching and mentoring staff, supporting them to understand and provide good dementia care. Our observations during the inspection indicated that the staff team seemed to understand how support people living with dementia. We saw staff effectively intervene to settle a person who crying out distressed. They took the person's hand and reassured them, spoke with them, and this had a calming effect. We were able to see that formal training in dementia care was planned for 28 staff in December 2015 and we were told that further training in managing behaviours which might challenge others was to be completed in January 2016. The manager told us that there were also plans to appoint both a dementia and a dignity champion who would be responsible for promoting best practice in these areas and would attend additional training and workshops work by the local authority starting in January.

The manual handling training for 3 care staff was 6 months out of date. We spoke with the manager about this who reassured us that this was now booked for early December and that they would only be working under the supervision of suitably skilled and trained colleagues until this training was completed, however, both staff involved in moving and handling interventions should have appropriate and up to date training. Whilst the staff we spoke with all appeared to have a good knowledge of the signs of abuse and neglect and were able to tell us about the actions they would take if they suspected abuse was taking place, we noted from a review of training records that a number of staff had not refreshed their safeguarding training in line with the provider's policy. Records showed that training for this was also booked for December 2015. In lieu of the formal training, the manager explained that safeguarding practice had been discussed at a development day which had been held for all of their nursing staff in August 2015. This had discussed case scenarios and the reporting process. 13 of the staff team were also new and had undergone an induction which had involved a basic training programme which covered fire safety, manual handling, infection control, health and safety, safeguarding people and dementia care.

Other training relevant to the needs of people had taken place. The chef and cook had recently attended a 'chef's forum' and dysphagia training. We were told that they would be responsible for cascading this learning to their colleagues. A number of the kitchen team had also been enrolled on nationally recognised qualifications in catering.

Is the service effective?

Four staff had undertaken training on taking bloods. Two staff had trained in male catheterisation and training session on maintaining good tissue viability was planned for December.

At our last inspection in June 2015, we found that staff had not been receiving regular supervision. We issued a requirement. The provider sent us an action plan which explained how they planned to address our concerns. At this inspection whilst improvements had been made, we found that the provider was still in breach of this Regulation. Appraisals had recently been completed with 27 of the 45 permanent staff. This was to assess their skills and knowledge and identify their learning needs and areas for development. A small number of supervision sessions had been undertaken with staff around particular practice issues. The manager told us that many more informal supervision sessions and coaching had taken place but had not been recorded. Staff did tell us that they felt well supported and felt that they were able to seek support or guidance from the leadership team at any time. We also saw that the manager had developed a framework that would help to ensure that from January 2016, each staff member had a designated supervisor who would be responsible for ensuring that they received six supervisions sessions a year.

At our last inspection in June 2015, we found that mental capacity assessments had not always been carried out in line with the Mental Capacity Act (MCA) 2005. We issued a requirement. 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. At this inspection, we found that the provider remained in breach of this Regulation. It was not clear that the principles of the MCA 2005 were being consistently and effectively applied. Most people living at the home would not have been able to give consent to many aspects of their care and treatment, however, many only had mental capacity assessments in relation to the use of bed rails and whether or not they could use their call bell. We were not able to see that consideration had been given to a person's ability to consent to their care plan and the actions covered by this such as administration of their medicines or manual

handling interventions. Some people had care plan consent forms signed by relatives without there being evidence that the relative had legal authority to do so. One person had mental capacity assessments and best interest's decisions in place regarding the use of bed rails and using a call bell, but they had awarded a Lasting Power of Attorney (LPA) for health and welfare which meant that the LPA was authorised to make decisions about the personal welfare of the person. Mental capacity assessments were therefore not required.

Some improvements had been made. At our inspection in June 2015 we found that whilst appropriate best interests consultations had taken place about the use of covert medicines, these had not been preceded by an assessment of the person's capacity. This is important as it helps to ensure that the person has not being denied the right to make a decision they are capable of making given appropriate support. At this inspection, we found that people had a 'covert medicines form' in place. This contained a signed statement from the prescriber/ GP saying that they had performed a mental capacity assessment which had confirmed that the person lacked capacity to consent to covert medicines.

The staff we spoke with had a good knowledge of the MCA 2005 and what it could mean to people living at the home. Staff had recently undertaken additional external face to face training on the MCA 2005. One nurse told us, "The Mental Capacity Act was brought in to protect people's right to make their own decisions for as long as they can and it is our job to ensure this happens". They continued "People may lose some of their ability to make important decisions, especially if they get dementia but they can still choose what to wear and what to eat. So they have capacity to make some decisions but maybe not the big ones... our records must show what decisions residents can make and we help them with the others". However, further improvements were required to ensure that each person who lacked capacity to make decisions about their care and treatment had a clear mental capacity assessment and a record of the best interest's consultation which supported staff to act and make decisions on their behalf. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

Further improvements were needed to training programme and to ensure that the Mental Capacity Act (MCA) 2005 and

Is the service effective?

its Code of Practice were used effectively and consistently within the service. We could not therefore improve the

rating for 'is the service 'Effective' from 'requires improvement'. We will check that further improvements have been achieved during our next planned comprehensive inspection.

Is the service responsive?

Our findings

At our last inspection in June 2015, we found that people were not always receiving care that was centred upon them as a person and met their known needs and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care. The provider sent us an action plan which described the improvements they planned to make.

This inspection found that further improvements were needed to ensure that people's care plans contained more detailed information about how their needs should be met. For example, one person's behaviour management plan recorded a list of possible interventions staff could use in the event of physical or verbal aggression. The interventions did not include checking the person's blood sugars. This was despite the person's diabetic care plan saying that signs of low blood sugar might be confusion and aggression. This person's diabetic care plan contained guidance that was not in keeping with current best practice in relation to diabetic care and did not record what a normal blood sugar range might be for the person, or the actions to take if the monthly blood sugar readings were outside of these parameters. We reviewed the care of another person who required a specialist diet due to swallowing problems. This person had previously needed treatment for aspiration pneumonia which meant they were at risk of further episodes of aspiration or choking. They did not however have a care plan which described the actions staff should take in the event of them choking. The person's food and fluid care plan stated that they should have 'plenty of fluids' but did not record a target fluid intake. We spoke to a nurse. They did not know how much fluid the person should have as a target intake. In addition although the person's fluid intake was recorded these were not being totalled each day which meant it would not have been possible for staff to effectively monitor whether the person was having an adequate intake of fluid or not.

We found other examples where the care plans did not seem to reflect the person's known needs and abilities. For example, one person's nutrition plan stated, 'ensure positioned safely so as not to put airway at risk'. This person was able to eat and drink completely independently and had no known choking risk. Many of the behaviour management plans were similar in content and recorded similar triggers and proposed interventions. They lacked

information about what might lead each of the people to become agitated and how staff might best respond to manage this. We found examples where people's records contained conflicting information about their needs or did not reflect their current abilities. For example, One person's falls care plan dated 13 November 2015 stated "I am not able to mobilise or stand with the aid of a Zimmer frame and the assistance of the carer any more". However their mobility care plan dated just one day later stated "My mobility is variable. I am able to weight bear for a short time. Most of the time I need to be transferred with the help of a stand aid and with the assistance of two staff and can walk a short distance as well".

Where people were being treated for skin damage and wounds, the records relating to these were not always sufficiently detailed. For example, the records of one person stated that on 14 October 2015, they had been assessed as having a grade two pressure wound. The person's records then showed that on the 20 November 2015 they were being treated for a grade one pressure wound. There was no information about how the skin wounds had changed between the two dates or if the latter wound was new. The wound care records did include two photographs but these were of a poor quality and would not have enabled staff to assess and monitor the healing of the pressure wounds.

Further improvements were required to ensure that people had care plans which helped to ensure that staff would be able to meet their needs. This is a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

We did find that some improvements had been made which helped make the service more responsive. Records showed that staff usually responded promptly when people became unwell. For example, we saw records which showed that a person had been referred to the doctor as they were not sleeping well. Another person as they were not eating well. One person had been referred for a review of their blood sugars as these were frequently being recorded as being outside of normal parameters for the person. We were able to see that people who were experiencing falls were referred for reviews by an occupational therapist. Short term care plans were put in place to assist staff with monitoring acute health care needs. For example, one person had a short term care plan

Is the service responsive?

which described the care needed to treat an infection of their suprapubic catheter site; although we did note that this was not being updated every two days as recommended within the plan. Another person had recently been reviewed by a speech and language therapist. Their revised guidance was available on the person's bedroom wall and we observed staff following this.

The records of daily care demonstrated that staff supported people to maintain aspects of their personal care, dietary needs and skin care in accordance with their care plans. These records were generally well complete with few gaps, although we did note that some of the fluid charts we viewed had not been totalled. This can make monitoring the person's fluid intake more difficult.

Overall people generally felt that the service was responsive to their needs and that the staff supporting

them understood their needs. One person said, "The staff are very good; they know me well". Another person said, "They know me well enough to know when I need the doctor". We saw one carer assist a person to the dining table as they knew that the person ate better sat at the table rather than in their arm chair. Staff were able to describe what was important to people and we saw them trying to help people to make choices such as what they would prefer to eat. A 'Resident of the Day' initiative was being introduced. This is an initiative that encourages all of the staff caring for a person to spend time getting to really understand what is important to them. It involves a full review of the person's care plans, their preferred daily routines or the chef speaking to them about their food likes. This initiative is yet to be fully implemented but will help to ensure the delivery of person centred care as staff really get to know what is important to each person.

Is the service well-led?

Our findings

At our last inspection in June 2015, we found that the service was in breach of the Regulation which concerns how the service assesses, monitors and improves the quality of the service. As a result we issued a warning notice requiring the provider to have made improvements by 28 October 2015. This inspection found that some improvements had been made, but that further progress was needed to ensure that the improvements made were embedded and sustained so that a fully effective quality monitoring system was developed.

We found that some audits had taken place, but these were still not being done on a regular or planned basis and so continued to lack effectiveness at identifying how areas of the service provided could be improved. The manager told us that a more structured programme of audits would be in place in the new year. Where audits had taken place, we were able to see that any improvements identified as being required were mostly being addressed. An infection control audit had been undertaken in July 2015. An action plan had been drafted as a result of this and reviewed in October 2015. This showed that many of the actions had been completed, for example, some flooring had been replaced, a rusty commode replaced and deep cleans performed. Three enhancing mealtimes checklist had been completed. Checks were being undertaken on a regular basis of the medication administration records (MARs) Where issues or concerns had been noted action plans had been drafted as a result of these and assigned to a nurse to complete. We saw that some of these actions had been completed. For example, protocols has been drafted which described the circumstances when people might need their 'as required' or PRN medicines to be administered.

Clinical risk meetings were taking place on a more regular basis and were attended by key staff. We saw from the minutes of these that these were being used to review risks associated with service user's nutrition, weight loss, diabetic care, tissue viability, falls and incidents of challenging behaviour. This meant that a key tool for sharing skills and knowledge, best practice and monitoring risks to people's health and wellbeing was being more effectively used.

At our inspection in June 2015, we had identified that concerns or issues raised by staff were not always acted upon. Staff did not feel listened to. At this inspection we

found that this appeared to have improved. We spoke with five care workers, their feedback about working at the home was positive. Staff told us the new management team were approachable and listened to their concerns. One care worker said, "Morale was quite low but the new manager is very open, friendly and supportive, this has made the world of difference and the home is now a much happier place". Another care worker said, "I enjoy coming to work, even though the shifts are long and I do get tired, we work as a really good team here and we work together really well, the manager is always available and helps with advice but practically as well".

Overall we found that whilst a number of improvements had been made, some elements of the warning notice had not been fully met. Many of the improvements made needed to be more embedded to ensure they were being fully effective. We will undertake another inspection of this service to check whether the improvements have been sustained. If concerns remain, we will consider further enforcement action.

At our previous inspection we found that the registered persons had not taken adequate steps to ensure that the CQC were informed about any allegations of abuse as required by the Regulations. At this inspection, we were able to see that CQC had been notified appropriately of safeguarding alerts which had been raised about aspects of people's care. There was evidence that the management team had worked with the local authority to investigate these concerns and robust actions had been taken to ensure any further risks to people were mitigated.

Visiting healthcare professionals told us that improvements were being made and were being driven by the new manager and leadership team. One said, [the leadership team] are leading well, the nurses are doing more, records have improved, staff are recording things on time". Another said, "They seem to be good leaders, we have worked well together to make improvements, it's driven by these guys, they want to learn and improve".

Most people were unable to tell us their views about the leadership of the home. However those that were spoke positively about the manager and expressed confidence in her ability to drive improvements and address their concerns. One person said, "The manager seems good, there is a good atmosphere here, it's warm and friendly". People told us that they felt the manager listened to their concerns and One said, "The manager inspires confidence,

Is the service well-led?

the relatives meetings have been helpful". We saw that the manager and staff had recently received some positive feedback from a family member, this said, "We really appreciate all the time, care and consideration given to [the person] during their stay with you, they were very well looked after and was content...you really have a wonderful nursing home and we are so glad that [the person] spent his last few months being looked after by your professional and caring staff".

We have not improved the rating for 'is the service 'Well Led' from 'requires improvement'. We will check that further improvements have been achieved during our next planned comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Where people lacked capacity to consent to their care and treatment, the registered persons had not always acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (3).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not ensured that each person had a care plan which helped to ensure that staff were able to meet their needs

This section is primarily information for the provider

Enforcement actions

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