

Austhorpe Care Home Limited

Austhorpe 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 caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

This inspection took place on 21 and 23 May 2018. The first day of our inspection visit was unannounced. The provider was given notice of the other date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

Austhorpe House was last inspected in May 2017 and was rated as Requires Improvement. At that inspection, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have enough suitably trained staff to meet people's needs, and the provider did not have robust recruitment practices. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Safe, Effective, Caring, Responsive and Well Led to at least good.

At this inspection, we found that improvements had not been made to ensure the provider delivered nursing and personal care that met legislative requirements. We found that the provider remained in breach of regulation 19 (Fit and proper persons employed). We also found a further four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Austhorpe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Austhorpe House provides personal and nursing care for up to 28 people over two floors. At the time of our inspection, there were 20 people living there. Austhorpe House provides personal and nursing care to people living with a range of health conditions, including physical disabilities and people living with dementia.

The service had a registered manager in place. 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.

The provider continued to recruit staff that was not compliant with regulations. The checks made on potential employees were not sufficiently robust. The provider had failed to make improvements in recruiting their own staff and were reliant on the high use of temporary staff. This had impacted on the quality of service provided as people's preferences had not always been met. We found there were inconsistencies in people's care records. Risks to people's safety were assessed but information was sometimes conflicting and lacking in detail about the action staff should take to minimise them. This presented concerns that, due to high levels of agency staff used, not all of them would be aware of the measures required to ensure people's safety.

The provider had failed to provide sufficient numbers of suitably qualified and competent staff. This had led

to incidences whereby the kitchen could not operate and cleaning schedules were not carried out.

People told us they felt safe at the service. Staff had an understanding of how to safeguard people from risk of abuse and were confident the registered manager would ensure any allegations of abuse were appropriately managed. Staff were trained in relevant areas, including health and safety and moving and handling. People's medicines were not always managed safely, and records gave conflicting information

People were supported to have sufficient to eat and drink, but mealtime experiences were not always enjoyable for people. People felt that improvements needed to be made to the quality of the food, but efforts to do this by the registered manager had been inhibited by the provider. People's needs were not fully met by the adaptation, design or decoration of Austhorpe House. The premises required extensive refurbishment and redecoration to provide a homely environment that met the needs of the people living there. The provider had no plans in place at the time of our inspection to address this.

People and their relatives were not supported to participate in designing or reviewing their care. People's needs and choices were not always identified and delivered in line with current legislation and evidence-based guidance.

The provider had not identified they were not making sure people's privacy and dignity was respected. People's preferences had not always been identified so that staff could provide care in the way people wanted. Where they were known, staff did not always respect these. Staff did not always promote people's independence, and the provider had failed to identify and provide equipment that would support this. Although staff were kind and caring, people did not always have their care provided in a dignified or private way.

People's care plans did not contain accurate, up to date or clear information for staff to help ensure that they provided a high standard of care and support to people.

Complaints to the service had been managed in line with the provider's stated procedure. People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time.

The provider's auditing system was not robust and had not identified the concerns we found during this inspection. The provider had not made improvements identified at the previous two inspections, and were not sufficiently responsive to concerns raised about the quality of the service made by commissioning bodies. Provider oversight of the home had not been sufficient.

The provider had not ensured that the registered manager received the support and guidance required to make the necessary improvements. The resources the registered manager had requested to meet people's basic needs had not been provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Improvements had been made to safe staff recruitment, but staff were still not recruited within legal requirements.

Improvements needed to be made to ensure that the service had enough permanent staff to ensure consistency for people and that their preference could be met.

Improvements needed to be made to ensure people were protected from the risks associated with cross infection.

Risks to people's safety were assessed but not always accurately. Staff did not have detailed guidance about how to minimise these risks.

There were shortfalls in the safe management of people's medicines.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had received the training, and had the skills required to support people.

Staff did not always seek consent from people before providing them with care and support.

The premises did not meet the needs of people living with dementia. Areas of the service were in need of refurbishments and repairs.

Peoples nutrition and hydration needs were met to keep them healthy although catering staff retention had negatively impacted on the provision of food.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People were supported to see their relatives and friends.

Peoples independence was not consistently promoted.

People using the service told us they liked the staff and found them helpful, friendly and kind. We saw staff treating people in a patient and compassionate way. However, some practices were not always respectful of people's dignity.

Is the service responsive?

The service is not always responsive.

The planning and recording of peoples care needs were not person centred.

People's preferences of how they wished their care to be delivered were not always met.

The service managed complaints appropriately.

Requires Improvement ●

Is the service well-led?

The service was not well led.

The provider's oversight of the home was insufficient.

Actions had not been taken to address shortfalls in the provision of care identified by commissioners and the Care Quality Commission. The quality of care provided had continued to decline.

The registered manager did not receive adequate support, guidance and oversight by the registered provider.

Inadequate ●

Austhorpe 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 May 2018 and was unannounced. We also returned on the 23 May 2018. The provider and manager were given notice of the other date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

On the first day the inspection team consisted of two inspectors', a specialist advisor in nursing care and one expert by experience. An expert by experience is a person who has personal experience of using this type of service. On the second day one inspector completed the inspection.

Before the inspection we reviewed information we held about the service including feedback sent to us from other stakeholders, for example the local authority and members of the public. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us prior to the inspection. We also spoke with the local clinical commissioning group quality assurance manager, and the local authority quality assurance manager.

To help us assess how people's care needs were being met we reviewed eight people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with five people living at the service and three relatives. We spoke with the registered manager, clinical lead, and four members of care and catering staff. We also observed the

interactions between staff and people living at the home.

Is the service safe?

Our findings

At our last inspection in May 2017 we rated this key question as 'requires improvement'. We found the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the providers recruitment practices were not robust. This included not seeking a full employment history as is required by law. They did not contribute to ensuring staff were properly suitable for work in care and so compromised how people were protected.

At this inspection, we found that systems had improved. However, there were still shortfalls in the records that are required by law. There was a checklist in place to ensure references and enhanced checks of people's backgrounds were completed before staff started work. This helped to ensure staff were of good character and not listed as unsuitable to work in care services. However, the provider's application form asked for ten years' employment history and an explanation of gaps only in excess of two months. Regulations require a full employment history and an explanation of any gaps. We reviewed the recruitment files of four members of staff and found that this full information was missing from all of them. This meant that the provider still did not obtain the information required by law.

This is a continued Breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people and their relatives as to whether there were enough staff on duty to keep people safe at all times. A visitor to the service told us that they had called to see their family member at various times during the week and at weekends. They said, "I have no issues with staffing. I come at different times and different days, including weekends." However, one person told us, "They sometimes seem short of staff. I may have to wait if there are only two of them on." Another person said, "There are only two staff on a night and I worry that there are not enough of them if something happens." Other people told us that there were not enough staff during evenings and weekends and that they had to wait.

The provider told us, they experienced difficulties in recruiting staff, and were reliant on the use of temporary workers provided by an employment agency. People told us that usually the same workers came to the service, and that they knew how to support them. People we spoke with told us that they preferred being supported by the homes own staff, because they felt that they knew them better. This included having their preferences of gender of the member of staff supporting them being met. One person told us that they preferred to be supported with intimate care by a person of the same gender as themselves, but on occasions this preference had not been met. They told us that this was because the majority of agency staff supplied were male, resulting in the registered manager not being able to ensure the staff rota reflected peoples preferred choices.

During our inspection, we asked the registered manager if there had been any action taken to address the difficulties in recruiting care staff to work at the home. They told us that it had been discussed with the provider, however, no actions had been implemented other than to continue to advertise for staff. A recent review of registered nursing staff pay had resulted in an increase, which the registered manager hoped

would help to retain them.

We reviewed recent staff rota's and saw that for the week before our inspection, 14 -20 May 2018, a significant portion of staff used were temporary and supplied via an agency. We also found that on three occasions not all shifts had been covered, resulting in less staff on duty than had been assessed as being required. To meet the assessed levels of support in the home, five care staff were needed for early and late shifts, and two care staff were needed at night. In addition to this one registered nurse was required for each shift. We found that of the 84 care shifts required to maintain the services assessed level of support, 41 shifts were covered by agency staff and 40 by the homes own staff, with two shifts not covered. We found that of the 21 nursing shifts required, six of these were covered by agency staff, 14 by the homes own staff with one night shift not covered.

Prior to our inspection, we received concerns from commissioning bodies that ancillary staffing roles such as kitchen and cleaning staff were not covered when absent on leave or ill health. This had been a decision taken by the provider. Consequently, the provider had not ensured alternative arrangements had been put in place to ensure people remained safe from risks associated with malnutrition and infection control. We found there had been a period where there were no regular staff available to cook meals for people. Arrangements had been made to provide meals by using a local public house, or to use local take away restaurants. It meant that people would not have the full choice of meal options available, as well as ensuring that specialist diets, such as soft and mashable meals being prepared by a staff member who was experienced and trained to do so. During our inspection, we found that carpets had not been hoovered for six days. When we enquired as to why, the registered manager explained that a domestic worker had been deployed to the kitchen to work, and that they had not been authorised by the provider to cover the domestic workers post with a temporary member of staff.

We saw that staff were available to respond to call bells promptly. However, we found arrangements for staff breaks were not organised. Three staff took their break together, resulting in a lack of staffing presence in the home, leaving vulnerable people alone, who would not have had access to staff promptly if needed. The registered manager indicated that this had been a problem and staff were not supposed to do this. The registered manager addressed this at the time of our visit.

We concluded that although the assessed level of nursing and care staff required was usually provided, the very high use of agency staff impacted on people's preferences being met. People living at the home regularly received care from people that they felt did not know them well. The provider had not taken enough actions to address this, and no future plan was in place, other than to keep advertising. The failure to provide cover for ancillary staff positions such as kitchen and cleaning staff, meant that these essential functions were not able to be provided. Alternative provisions such as takeaway foods were not safe or satisfactory to people living at the home. We also found this to have an impact on the hygiene and cleanliness within home.

This is a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were assessed, for example in relation to poor dietary intake, falls and to their skin integrity. Despite this, we found information was sometimes conflicting and lacking in detail about the action staff should take to minimise risks to people. This was mitigated because there was a core of long standing staff who understood people's needs. However, the lack of detail and inconsistencies presented concerns that, due to high levels of agency staff used, not all of them would be aware of the measures required to ensure people's safety.

We found there were inconsistencies in people's care records. For example, one person's assessment ticked that they were eating poorly or had a lack of appetite. Elsewhere, their records indicated they had no problems. Their weight was monitored regularly but showed significant fluctuations. For example, between 14 June 2017 and 3 September 2017, staff recorded the person's weight as having declined from 49kg to 39.9kg meaning they had lost 20% of their bodyweight. There was no indication in the person's records of any additional interventions, or any enquiry into whether this was an error requiring repeated weighing or investigation of the calibration of the scales. However, they had recovered their weight back to 49.8kg very quickly.

The person had experienced further problems between 12 November and 1 December 2017, when their weight was recorded as having dropped from 51.7kg to 46kg. Their Body Mass Index (BMI) was recorded as having declined from 18 to 16.9 during the same period. An index of below 18.5 is considered to indicate that a person is underweight. The person's assessments using the Malnutrition Universal Screening Tool (MUST) between May and October 2017, did show that they were at high risk from not eating enough.

On 17 December 2018, the electronic care plan system had flagged up in their daily records that the person had lost 6.93% of their body weight. This should have triggered, in line with MUST guidance, further intervention. However, the December review of their MUST assessment reduced their risk from high to medium. There was no review of their plan of care until 23 December. That review recorded that their diet and fluid intake had been good and so did not fully consider the significant loss.

We could see in recent records that the person had fluctuated but that on 15 April 2018, it had recovered to 50.1kg. By 7 May 2018, they had once again lost 2kg but regained almost one and a half of these at the point of our first inspection visit. The clinical lead nurse told us that she considered the very significant fluctuations to be due to staff errors when weighing the person and that, where they were aware of large fluctuations, staff were asked to repeat the exercise to ensure it was accurate. We found in some cases, there was a lack of oversight of these records to show when further exploration or investigation was needed.

Despite a lack of guidance, we found that the person's food intake was regularly monitored. Staff assisted the person with all their drinks and meals and completed records each day. However, there was a lack of clear guidance for staff in care plans, about actions needed because of any change.

Care plans for eating and drinking did not clearly show whether people needed their meals prepared in a particular way to minimise risk of weight loss. For example, one person's record showed in relation to their diet they had "reduced appetite special diet – normal diet, normal fluids." This lacked clarity about management of risk.

Catering staff knew which people were at risk of weight loss and could show us clearly who these people were. They also knew who was diabetic and needed consideration of their diet to ensure their wellbeing. However, we did find that an assessment for one person had ticked that they were diabetic and this was not flagged up anywhere within their plan or on the information in the kitchen. We spoke to the clinical lead nurse about this, who told us it was a mistake in their records. For another person, their electronic care records indicated they were diabetic but the hand over record staff referred to did not show this. The clinical lead nurse told us that they would clarify this.

Nursing staff assessed the risks posed to people's skin integrity, and the likelihood of developing pressure ulcers and reviewed these regularly. However, two separate assessment tools were in use, the Norton Scale and Waterlow assessments. For two out of three people whose records one inspector checked, these gave different results. This presented a concern that risks would be under-estimated. For example, for two

people, their Norton Scores indicated they were at high risk and their Waterlow assessment showed medium risk. For one of these two people, nursing staff had failed to take account of the person having experienced a stroke and which increased their risk so that the Waterlow score should also have indicated high risk.

The provider's policy and procedure for pressure ulcer management, was updated in November 2017. This contained information about best practice and quality guidance, which nursing staff could access on the internet. It also stated that people with grade three or four pressure ulcers, or with a deteriorating ulcer, should receive additional specialist advice, for example from a tissue viability nurse. We could see that the outreach nurse from the GP's practice was contacted in one such case. We could also see that the registered manager had emailed the specialist service requesting some input but had not received a response. We understood from our discussions, that there would be a charge for such a service and that it had not been possible to arrange.

The policy stated that, 'The nurse responsible for wound management will refer to the Royal Marsden Manual of Clinical Nursing Procedures for current recommended practice.' The registered manager and clinical lead nurse told us this was not available in the home for nursing staff. This was contrary to the provider's policy.

The equipment people needed to minimise pressure ulcer risk was specified in plans. Where air-flow mattresses were necessary, the setting for each of these was included in records and checked regularly. This helped to minimise risks to people's skin integrity. Records kept in people's rooms showed when they were encouraged to change position so that risks of developing pressure ulcers would be minimised.

However, staff did not always complete the timings on these to show clearly what had happened. For example, we found one chart for 20 May 2018 recording that the person was 're sat up for breakfast' at 7.15am and then 're sat up' at 9.45am. At 12.30pm they were assisted to sit up for their lunch. There was no indication between the times of these three entries that they were placed either on their left or right side to relieve pressure on their back. On the second of our inspection visits, we found that records were more consistent in recording timings and how the person had been assisted to move and so relieve pressure on vulnerable areas.

We found conflicting information about the equipment that staff should use to move and transfer one person safely. One piece of information showed that staff needed to use a small sling with the hoist, where another part showed staff needed to use a medium sling. This presented a concern that, if the sling was not an appropriate size, it could fail and that the person would not be as comfortable and safe as they should be when staff assisted them. The clinical lead nurse told us that they would follow this up to ensure records and practice was consistent.

The registered manager informed us that there had been problems with the call bell system people used to summon assistance when they needed it. Planned improvements to improve coverage provided by the system had not been made. For example, we found that one call point in the conservatory was being appropriately used for a pressure mat to alert staff to a person's movements. However, this meant that there were no other means for people at that end of the room to use the call bell. At the other end of the conservatory, the cable was unplugged and hanging up on the wall. There was no one sitting in the area and the ability to summon assistance if necessary, would have relied upon one person being positioned where they could use it on behalf of others. There were no pendant alarms in use.

We concluded that identifying risks to people and the monitoring and management of their safety, was not

always completed consistently and accurately. This meant that people living at the home did not always receive safe care in relation to the risks posed to their health.

This is a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people associated with falls were documented. We noted that staff positioned a pressure mat for one person so that the call bell would alert them if the person tried to move independently. They could then intervene promptly to ensure the person's safety.

Risks to people's safety associated with the premises, were kept under review. However, we found potential concerns for the control of Legionella bacteria in the water system. The testing report showed that the Legionella bacteria found were not of the strain associated with significant risks to health, but that there were conditions favourable to the growth of bacteria and could include species associated with fatalities. A member of the maintenance team told us how they had ordered the chemical needed for disinfecting the system and this would take place when it was available. They told us, and records confirmed, how they flushed the water system throughout the home to ensure that they had acted on recommendations from the Health and Safety Executive to minimise risk.

Systems for detecting and extinguishing fires were tested regularly and staff had guidance about how to ensure the safety of individuals should a fire break out. We also noted regular checks on equipment used for assisting people with their mobility and on electrical appliances.

There were programmes of audits and checks on safety of individuals and associated with the premises or activities people and staff might undertake. This included risks associated with a forthcoming event involving miniature donkeys that people were looking forward to. We also found that a variety of craft activities were assessed to make sure these, and the materials used, would not present undue concerns for people's wellbeing and safety.

Systems for minimising the risk of infection, and for controlling any outbreak, were not properly effective. We noted that some areas had not been cleaned regularly. For example, in one person's room we found there to be a pile of nail clippings on the floor. We asked the register manager about this, they told us that these would have been left from the chiropodists visit during the previous week. They went on to tell us that cleaning staff had been redeployed to work in the kitchen, which meant the cleaning schedules had not been completed.

Audits showed medicines rooms were not always clean. This was recorded on three successive checks in January, March and May 2018 so was not consistently addressed. Specific infection control audits completed in the home also showed some concerns, including high surfaces and floors, and that curtains were not changed and cleaned regularly. The audit completed by the clinical lead nurse between our two inspection visits, also included reference to some tables being chipped so these could not be properly cleaned. We concurred with this view. For example, we saw that a table available in the conservatory people to eat their meals or engage in activities had damaged corners. The edging strip was missing all the way round, exposing porous chipboard filling. This presented a risk of harbouring infection and it could not be cleaned properly. We spoke to the registered manager about this who told us that as far as they were aware, the provider did not have any plans to replace the damaged equipment.

The upstairs clinic where medications are stored was clean, tidy and well organised. However, the downstairs clinic room has a soiled cracked sink, work tops were not sealed and fluids could get in and not

easily be wiped away. This presents a cross infection risk as damaged surfaces cannot be stringently cleaned. We spoke to the registered manager about this who told us that as far as they were aware, the provider did not have any plans to replace the sink in this area.

Sharps bins were stored in front of a low and open window which could be accessed from a patio area. Unused medications were also stored in an open bin in this room. Both these items should be stored securely to prevent harm from cross infection or overdose. We informed the registered manager of this who acted to secure this area and the items within without delay.

Staff used PPE [Personal Protective Equipment], for example when handling foods or supporting people with medicines, and ensured they used fresh PPE for each task undertaken. Staff also carried clinical waste in sealed bags. These measures reduced the risk of cross contamination.

Staff who were engaged in the preparation and storage of food had the knowledge and qualifications to do this safely and in line with current published guidance. Catering staff we spoke with could demonstrate how they did this on a daily basis.

We identified shortfalls in some areas in the management of people's medicines. Medicines administration records (MAR) contained a front sheet which included photographic identification for residents and included a list of allergies. Information about covert medication administration was also recorded on this front sheet where required. However, not all front sheets match the information within the main body of the MAR. One person's record stated 'no allergies' but their MAR records allergies to three types of strong medicines.

Where people required 'As and when required' (PRN) medicines, protocols and recording sheets of when these were administered were in place for some but not all of these medications. These records and protocols are important to ensure that these medicines are given in the right way and only as the prescriber intended. In one person's record, there were three places to record administration of a strong opiate based medicine, the PRN record, a printed MAR and a hand-written MAR. There is a risk that the staff may only check one sheet and would therefore not be aware if a previous dose had already been administered which would put people at risk of an overdose.

Not all PRN protocols consistently stated a maximum daily dose. Some that we reviewed had conflicting information. For example, one record stated the maximum dose for a person's inhaler is two puffs per 24 hours. This conflicts with the MAR which states two puffs as required. Restricting to one dose per 24 hours may put this person at risk from the symptoms of their shortness of breath.

When administering medicines staff sought consent from people, including carefully observing any non-verbal communication. Details of how people preferred to take their medicine are recorded in peoples records and we saw that this was followed. People were involved in the process of taking medicines, for example, we saw a nurse administering a medicine explain what each one was for and how to take it. We observed them asking the person if they would like their tablets one at a time or all together. We also saw that insulin was administered safely and one person comment to the nurse doing this, "You are lovely". The nurse told the person what their blood sugar level was and they said, "That's good". This meant the person could take part in their own health monitoring and make informed choices about their diet. There were no gaps in recording in people's MAR charts and entries were clear and legible. Staff consistently completed body maps for the application of patch's which delivered some peoples medicines to ensure that the same area was not regularly used.

One resident received medicines covertly, the record of their capacity assessment shows this has been

discussed with their GP, assistant social worker and family and deemed to be in the persons best interest. Staff liaised regularly with GP for advice regarding medicines including for anticipatory end of life medicines.

A regular visitor to the service told us that they had never had any concerns about the way staff conducted themselves towards their family member. They also said that they had not witnessed or heard anything in staff interactions with others that had raised concerns for the way staff treated people. All the people we spoke with told us that they felt safe. One person told us, "I feel safer here... There is always someone around to keep an eye on me."

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact information. Safeguarding procedures are designed to provide staff with guidance to help them protect adults from the risk of abuse. Staff had all undertaken training in this area and demonstrated a good awareness of safeguarding procedures. They also knew who to inform if they witnessed or had an allegation of abuse reported to them. They were confident the registered manager would act on their concerns and were aware they could take concerns to organisations outside the service. The registered manager and deputy manager were aware of their responsibility to liaise with the local authority if safeguarding concerns were raised and previous incidents had been managed well.

Is the service effective?

Our findings

At our last inspection in May 2017 we rated this key question as 'requires improvement'. We found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that staff had not received the training and support they required to effectively meet people's needs.

At this inspection, we found that staff training had improved, and the service was no longer in breach of this regulation. Staff now received regular supervision and training. Records showed staff had the opportunity to discuss any concerns and that supervisors gave positive feedback as well as identifying any improvements needed in performance. The regular supervision of staff practice contributes to people receiving effective care from competent staff. The registered manager had ensured staff were up to date with required training such as safeguarding, first aid, manual handling and fire safety. Nursing staff were supported to maintain their training in line with their registration. Recently recruited staff received a comprehensive induction, which had been designed by the registered manager to reflect the needs of people using the service. This drew on nationally recognised qualifications and guidance, including the care certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support.

However, this key question remains rated as 'requires improvement' as we found the design and decoration of the service did not meet people's individual needs and other quality of care issues. People we spoke with felt the repairs and improvements were needed. One person told us, "The home is really old and could do with some repair." Another person told us, "I know the building is a bit old, but they have tried to adapt it the best they can. Some of the furniture could do with replacing."

We saw during our inspection that two of the homes adapted bathrooms with equipment to allow people with limited mobility to take a bath or shower were broken and out of use. These areas had been out of use for over 12 months. The registered manager told us that the provider did not have a plan in place to repair these anytime soon. This meant that people living in the area of the home with the non-functioning bathroom, would have to travel to another part of the home to use one that was functioning.

The corridor carpets in the majority of areas were extensively worn and in some cases dirty. The main conservatory area where people ate, did not have any dining room chairs so that people could sit around a dining table to eat. This meant people ate in an armchair or their wheelchair, compromising their ability to help themselves, or sit with a friend or family member. We asked the registered manager about this, and they told us that there was no budget available to purchase these chairs. The armchairs in the conservatory area had worn and dirty fabric covers, and of the nine spotlights in the room, six were not working which made the area appear gloomy as the blinds were closed to keep the heat from the sun down.

Some people at the service were living with dementia. We saw that dementia friendly signage had been placed on some bathroom doors however, communal areas such as the lounge had not. Corridors, exits and entrances had not been decorated so that people who could become confused could navigate around the

home more easily. We saw that minor repairs had not been made, for example, a broken corridor window had sellotape place over it rather than a permanent repair. Paintwork on walls and doors was damaged and dirty, and the central courtyard patio, was regularly used by staff and contained a large container of cigarette ends which smelt strongly. The potted plants in this area had all died, and the borders had become overgrown and was unsightly for people and their visitors to look at. The area was not designated as a staff area but was treated as such meaning people living at the home could not access all the areas at their free will. Other outdoor areas of the home however were accessible and had been kept in good order and were enjoyed by people living at the home.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

When people were unable to make some decisions for themselves, mental capacity assessments and best interest decisions were recorded. Most contained evidence of the involvement of the person's family members and other professionals in the decision-making process. We found that people had been consulted about the care they received and had consented to its provision including all areas of care such as permission for staff to enter bedrooms, consent for photographs and consent to care. The registered manager was aware of any relatives with Lasting Powers of Attorney that have bearing on the decision making where a person did not have capacity to make a specific decision. Where DoLS applications were required to be made, these had been completed without delay.

However, we observed that staff did not always ask people for consent before performing certain tasks and did not always offer choice, such as supporting them to eat a meal. Some staff practice we saw demonstrated that staff may have assumed the person could not consent. This was because we observed some of them making decisions for people without asking them or supporting them to make a decision. We observed that consent to care was not consistently sought and choices about activities of daily living were often made by staff not residents. Three people we spoke with told us that staff did not seek their consent before providing support. One person told us, "One [staff member] asked for consent, but the others don't bother. It's probably not right is it?" Another person said, "The staff don't always ask you before they do anything." During our observations of people receiving care, we frequently saw staff provide care without seeking peoples consent, or advising them what they were about to do. This included placing aprons on people, moving people in their wheelchairs and lifting their limbs.

Staff ensured that they assessed people's needs although records were sometimes inconsistent in how well they guided staff about the care they should deliver. The registered manager went to assess the needs of one person considering moving to the home, during the first of our inspection visits. There was guidance about good practice available both through links in electronic copies of policies and procedures and, in some cases, displayed within the home for staff to refer to. As this was a nursing home, registered nursing staff were also expected to abide by their professional codes to ensure best practice and that they kept their knowledge up to date. A relative told us how well they felt staff delivered care to meet their family member's

needs and that this had resulted in an overall improvement in their standard of health since they moved into the home.

We received mixed feedback about the quality of the food provided at Austhorpe House. One person told us, "The food is alright I suppose. They will get you something else if you don't like what was offered." Another person said, "The food could be better. It's not always cooked very well and they often have things I don't like."

Staff supported people to maintain a balanced diet and to have a choice of food and drink. A relative told us that they were pleased their family member had lost weight. They said that the person had needed to because of an underlying health condition. They told us that staff had been successful in stabilising the condition as a result and had no concerns about the person's diet or fluid intake. They told us how much their family member enjoyed their meals.

We observed that staff encouraged people to drink and offered drinks regularly. We saw one staff member encouraging the person with extra drinks because it was a warm day, and particularly warm in the conservatory where they were sitting. The same member of staff also showed people a choice of biscuits to have with their mid-morning drinks and ensured they gave people what they had requested.

Risks to people from choking on either food or drink were assessed so that staff could assist them safely. We saw that there was guidance on thickening products used for drinks for each person and that staff used them. The amount people drank was recorded so that staff could take action if people were at risk of dehydration. In the records we reviewed, each person was identified as having a target intake of a litre a day and information showed staff monitored this. Records showed that people achieved the expected intake through drinks. They would receive additional fluids through some of the foods they ate.

There were drinks available to people in their rooms and bottles of squash and a jug of water in the conservatory. We could see that staff had offered these to people who had them within reach. There was also squash and water in the small dining room. However, on the first day of our inspection visit, there was only one glass. On the second day, there was none. The registered manager reported this room as little used by people currently living in the home.

We found records of a recent food satisfaction audit, undertaken on 19 April 2018. This provided opportunities for people to suggest any improvements and what they would like to see on the menus. The registered manager's notes showed that she had followed this up promptly on 20 April, to discuss both positive and negative views and to include new items on the menu in response to people's suggestions.

The registered manager told us in their provider information return (PIR), that they had plans to introduce "snack boxes" so that people with small appetites could access these when they wanted to. This had not happened by the time of our inspection visits.

Staff assisted some people with their meals in their rooms as they wished, or because their health and frailty made it difficult for them to sit comfortably in the conservatory where most people spent their time. We also found that people in the conservatory were largely served their food on small tables while they were sitting in their arm chairs. There was a lack of suitable seating around the one dining table available for people to sit and eat together, although on the second of our inspection visits, two people did sit there and engage with one another, one using their wheelchair.

A visitor told us how much they felt that their family member's health had improved since they moved into

the home. They told us that care and nursing staff understood the person's health needs. They were confident that, if their family member became unwell, staff, including nursing staff, acted to follow this up and would involve their GP if necessary. They said that they were kept up to date with any changes in the person's health or wellbeing.

People received support and advice from other professionals. This included in relation to eyesight, hearing and oral care. Where people needed glasses or hearing aids, this was reflected in their records so that staff knew what they needed to help promote their wellbeing.

Is the service caring?

Our findings

At our last inspection in May 2017, we rated the key question of Caring as Good. At this inspection, we found that improvements needed to be made to ensure people's independence, privacy and dignity was promoted and maintained. We rated this key question Requires Improvement.

Staff we spoke to could describe how they would ensure people's privacy. We observed most staff knocked before entering people's bedrooms, although some people told us that this did not always happen. When providing personal care staff told us that they ensured curtains were pulled and doors closed. However, we observed staff conversations about providing support to people take place across a room, where other people were present and could hear. This meant that information was shared that could compromise a person's privacy and dignity.

People told us that staff promoted their independence and maximised people's ability by encouraging them to do as much as possible with support if they needed it. However, some opportunities to promote autonomy and independence were missed. For example, when staff took over tasks such as pouring drinks for, or wiping faces of people, who were willing and able to do this themselves.

We also found that people in the conservatory were largely served their food on small tables while they were sitting in their arm chairs. There was a lack of suitable seating around the one dining table available for people to sit and eat together, although on the second of our inspection visits, two people did sit there and engage with one another, one using their wheelchair.

We observed that one person in frail health and living with dementia, was cared for in bed. We saw that staff had taken care to ensure they maintained their appearance. The person's hair was neatly groomed and tied back. Staff assisted some people with their meals in their rooms as they wished, or because their health and frailty made it difficult for them to sit comfortably in the conservatory where most people spent their time.

A visitor to the home said that they always found staff polite and friendly. They said that they displayed a lot of patience towards people and they had never found staff to be short tempered or intolerant with people. We heard one person telling a staff member while we were present, "I like it here. People are very good to me. I'm happy." People and their relatives told us that staff were caring. One person described them as, "Pretty good, patient, cheerful." A relative said, "My [relative] would not be with us now if it wasn't for the staff here and the way they look after her. I think they are all wonderful, the staff are so friendly and always make us feel welcome." Relatives told us they felt welcome in the home and could visit any time they liked.

We observed positive communication throughout the day between staff and people. We saw that a staff member intervened promptly when a person became upset having spilled a little drink. They offered reassurance and mopped up the spill, assuring the person, "That's okay. It doesn't matter." Another person experienced some difficulty coughing. The same staff member approached and asked promptly if they needed help.

A visitor to the service told us how they were able to support their family member with decisions about their care. They said that they were consulted about changes in their family member's care plan if any were necessary. The registered manager had taken steps to support and involve people in planning and making decisions about their care. We saw that where they were able to, people and their relatives had been involved in the development of their care plans.

Is the service responsive?

Our findings

At our last inspection in May 2017, we rated the key question of Responsive as Good. At this inspection, we found that improvements needed to be made to ensure people were provided with care that was centred on their individual needs. We rated this key question Requires Improvement.

Processes for recording the care and support each person needed, were not sufficiently focused on the needs of each individual. The registered manager and clinical lead nurse acknowledged that there were issues with person centred care planning and that plans of care were not yet as good as they wanted them to be. However, there was a core of long standing staff members who were aware of people's individual needs.

We found that the majority of records were standardised, repeating phrases and not reflecting the needs of each individual. For example, one person's care plan for communication directed staff to, 'Use word boards, Makaton or BSL [British sign language] if [person] has understanding.' Makaton is a form of sign language used by people with a learning disability and so not appropriate. Staff had no training in BSL and when we asked, there were no "word boards" in the home. However, elsewhere in their plan it was recorded that the person could communicate verbally and to indicate their needs. The written guidance for staff was therefore inappropriate and not reflective of the person's needs.

We observed that one person, being supported in their room, had their radio tuned to some music that was inconsistent with what their own music indicated was their preference. When we checked their own CD's in their room, their selection included sing along discs, tunes from the musicals and singers such as Dean Martin. Their radio had been playing T Rex, Madness and Stevie Wonder so was not wholly consistent with their past preferences, which they could no longer clearly express verbally.

People were not all offered choice and control about how and when they preferred to receive their care. One person told us that they were not always given a choice about the time then went to bed in the evening. They told us, "They will let me stay up if I am watching something on the television I like. Sometimes they will put me to bed earlier if it suits them. I went to bed at 5pm yesterday." They went on to tell us that this was not their choice and that this was done to, "Suit staff rather than me." Another person told us, "I can't always choose when I get up or go to bed. Sometimes they seem to want to get you to bed a bit too early." A further person said, "I don't always have a choice about what time I get breakfast. Sometimes they come a bit too early. I want a lie in some days."

Another person we spoke with told us that they were not offered a choice of male or female carers. Care plans we looked at did not identify whether people had a preference. The person we spoke with told us, "I don't like men washing me, they [staff] know this but still they come." We spoke to the registered manager about this. They told us that the majority of staff that were provided by an employment agency were male. They went on to say that due to the very high use of agency staff, it was not always possible to provide people with a carer of their gender preference.

This is a Breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find that nursing staff completing one plan, had taken care to avoid the use of standard phrases, provided within the electronic care planning system. The information contained a lot of detail about the person's wishes and preferences. The person was very particular about how their meals were presented. There was clear information for staff about how they liked their food covered because they preferred cling film to metal covers. It contained detail about how they might struggle to uncover their meal if staff used too much. The plan also directed staff regarding the person's wish that staff kept their fingers to the very edge of the plate when they presented the person with their meal. The same person's plan also reflected the potential for the person to become socially isolated, but considered their wishes and abilities to maintain contact with family and friends independently.

A visitor to the home told us how they had expressed concerns about social isolation for their family member in the past. They said that they knew their family member liked to see what was going on around them, even if their communication and memory was impaired. They had expressed the wish that their family member spend time with others, which they knew they would enjoy. They told us they felt the service had been very responsive to these issues. They explained that the person had been supported to move rooms when one on the ground floor became available and spent some time each day in the conservatory with other people. They told us, "I wanted [person] to be more involved." They explained that staff had respected this and that their family member was happy with the arrangements. They went on to say that staff were always able to explain if there were exceptional circumstances meaning their family member needed to be in their room.

They also felt that staff were very alert to any changes in their family members wellbeing. They were confident that, if the person showed anything unusual for them, such as lacking interest in their meals, staff would recognise the change and act to investigate what was wrong.

Staff told us that the home proactively involves friends and family. We observed many visitors to the home and they were involved in supporting people living at the home. For example, one volunteer comes in and helps in the garden, another makes resources for the activity co-ordinator. At Christmas a local Primary school comes in to sing carols for the residents. The activity co-ordinator told us that they were busy planning for a garden fete the following weekend which they hoped would attract visitors from the local community. The activity co-ordinator organised a comprehensive range of things for people to do. People who did not wish to be involved in a group activity were offered other things to meet cognitive needs including wooden puzzles. People's bedrooms contained a range of items which show their engagement in hobbies and interests including dolls, music, magazines and books.

We reviewed the arrangements for handling complaints and found that there were no complaints requiring intervention or investigation by the registered manager within the last year. A relative told us, "I feel I need to be an advocate so I can speak up for [person] but I haven't needed to." They explained that they had only ever raised minor issues and that staff always acted. They described the service as, "...Very responsive".

Although no one living at the service was receiving end of life care at the time of our inspection, the registered manager told us people had received appropriate care and support at the end of and their life. This included working in partnership with healthcare professionals, including the local palliative care team and others. The home advertises that it provides end of life care as a speciality, but currently has no accreditation from a framework to provide this care within nationally recognised guidelines and standards. This was identified as a shortfall at our last inspection. The registered manager informed us that since our

last inspection, the home had registered to become accredited with the Six Steps Framework for providing end of life care. This is a nationally recognised framework and this process was arranged to commence in September 2018. The registered manager told us that in the absence of any accreditation, they had not offered placements to any person who would require palliative care.

Is the service well-led?

Our findings

At our last two inspections, in July 2016 and May 2017 respectively, we found that the leadership and management of the home needed to improve. We rated the service as requires Improvement at both of those inspections. At this inspection, we found that although the registered manager had tried to improve the quality of care in the service, they had been significantly restricted in their attempts to do this by the registered provider. Oversight of the service by the provider was insufficient and commissioners had not seen the improvements that they required the provider to make. This inspection found that the care provided to be requiring improvement in all areas, as well as multiple breaches of the regulations, we have therefore rated the key question of Well Led as inadequate.

Prior to this inspection, we received concerns from the local authority quality assurance officers, and the quality officers from the local clinical commissioning group. This was in relation to the failure to make improvements already identified, and the lack of communication and engagement by the registered provider. Assurances given at a subsequent meeting between the registered provider and these commissioning bodies were not delivered. The officers of these bodies also reported that they did not receive updates from the registered provider as to any progress as previously agreed. They also reported a failure to do this even after multiple requests were made. These officers reported that through their own checks, they had identified that the quality of care was not improving sufficiently. They also found a failure to provide the resources and support required to the registered manager, that would enable them to improve the quality of the provision of nursing care.

The records we reviewed showed that the last visit by, or on behalf of the registered provider to check the quality of care provided at Austhorpe House, took place on 11 January 2018. This visit was undertaken by an independent consultant on behalf of the provider. The report from this visit identified widespread and significant concerns regarding the quality of care provided at the service, progress in achieving compliancy to the regulations, and the support to the registered manager. The report stated that since the previous visit carried out in November 2017, 'More challenges were provided than progression.' It went on to detail challenges that required, 'Immediate intervention.' The registered manager showed us their action plan which they were using to monitor progress in making improvements identified by themselves or quality assurances officers. This identified that progress was not being made to address shortfalls in key areas such as recruitment of staff, the quality of food provided, improvements in the fabric of the building and equipment, and quality of care provided to people. Since this last visit, no further visits had been made. Following our inspection, we wrote to the provider with our concerns regarding this, and they informed us that they were making arrangements for a newly appointed independent consultant to undertake a visit and audit of the home.

The registered manager told us that they had not had an appraisal of their performance since coming into post over a year before. Neither had they received any supervision, or support to maintain their clinical knowledge as a registered nurse from the registered provider. They had made arrangements locally for themselves to become a member of a network of registered managers. During the inspection, the registered manager informed us that they had resigned from their position, but intended to continue working their

notice period of three months. They also told us that since tendering their resignation the week before, this had not yet been acknowledged by the registered provider.

Following our inspection visits to the home, we wrote to the registered provider to ask them to provide information regarding the concerns we had identified. The registered provider sent us an action plan to address the issues, however, was insufficient in detail, and did not provide the information we asked for. We again contacted the registered provider, by telephone, to ask for the information required. The registered provider did respond, however, the information given was basic and did not detail how the required improvements would be resourced and implemented.

There were systems implemented by the registered manager for monitoring and auditing the quality and safety of the service, although improvements were not always made and sustained. This included where there were issues about cleanliness and infection control. We also found that, having transferred care records from a largely paper based system, to an electronic care planning system, robust checks on the effectiveness of the system and how staff were using it had not been completed. This meant that the shortfalls we found were not consistently identified and addressed.

We concluded that the oversight and actions of the registered provider had not been sufficient in order to make the improvements required that were identified at the previous two inspections. The quality of the service since the last inspection had declined despite the efforts of registered manager to make the improvements that they had required.

This is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager could show how they had involved and consulted people about the quality of care and empowered them to express their views. They had displayed the findings of their survey in the hallway so that relatives could also see it. We noted that, where suggestions had been made for improvements these were considered and changes made, for example around food.

A relative confirmed to us that they had also recently received a survey to ask them for their opinion but had not yet completed it. Compliments and greetings cards supplied by visitors and relatives showed a high level of satisfaction with the care people received, as did comments on an internet review website.

Staff working at the home told us that they felt very well supported by the registered manager. They also told us that they felt the service had become a better place to work since their arrival, and that morale and team work had improved. Staff told us that the registered manager was approachable and were confident that any concerns they raised would be appropriately managed.

It is a legal requirement that a provider's latest Care Quality Commission (CQC) inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered persons had conspicuously displayed their rating both in the service and on their website.

Services that provide health and social care to people are required to inform, CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner in line with CQC guidelines.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	Regulation 9 HSCA RA Regulations 2014 Person centred care. Peoples care had not always been planned and delivered to meet people's individual needs. People preferences were not always met.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance. Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for acting upon the views of others, were not operating effectively.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Diagnostic and screening procedures	Regulation 19 HSCA RA Regulations 2014 Fit

Treatment of disease, disorder or injury

and proper persons employed. Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care.

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

Regulation 18 HSCA RA Regulations 2014 Staffing. The provider had failed to ensure that sufficient numbers of their own care, catering and domestic staff had been employed in order to meet people's needs and preferences.