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

Summary of findings

Overall summary

The inspection took place on 24 May 2017 and was unannounced.

Austhorpe House is in a rural location and consists of an old building on two floors and with a more modern and purpose built ground floor extension to one side. It provides nursing care for up to 28 older people, some of whom may be receiving palliative care at the end of their lives. The service provider says they will only accommodate 24 people. At the time of this inspection, there were 19 people using the service.

There service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of this inspection, the previous registered manager had supported a new manager through their induction and had left the home. The incoming manager had assumed full managerial responsibilities for the service around three weeks before our inspection but had not yet registered with CQC.

At the last inspection in July 2016, we asked the provider to take action to make improvements to medicines management and this action has been completed. Medicines were being managed in a safer way and the manager was working with the pharmacy supplying medicines to ensure further improvements were made.

However, we found that other improvements to the service were needed to ensure it supported people safely and effectively. Although there were enough staff to support people safely, recruitment practices were not contributing to protecting people from the employment of unsuitable staff as robustly as they should. Staff had also not received some elements of training they needed to support people competently and safely. Time-limited training was not renewed and updated promptly when it was needed to ensure staff remained up to date. Concerns about recruitment and training meant that we identified breaches of two regulations.

Improvements were needed to the way that risks were assessed and to address the lack of guidance for staff about the action they needed to take to minimise these. Care records lacked detail about these risks as well as about how staff should meet people's individual needs and preferences. The effect of this was mitigated to some extent because of a core of long-standing care staff who had got to know people well and how they liked to be supported.

There were systems in place to assess the quality and safety of the service people received. However, this did not always result in improvements being made in a timely way and the service provider had not been able to adhere to their own timescales for improvement. The manager was aware of shortfalls within the service from both internal and external audits. However, they had not been in post long enough to speed up the pace of improvement and to sustain it. The manager anticipated that this would improve with the strengthening of the management team by appointing a deputy manager.

Staff were kind, caring and compassionate approach in the way they supported people and took people's preferences into account. They supported people in a way that respected their privacy and dignity. Staff understood the importance of seeking both people's views and their consent before delivering care and of acting in a way that took into account people's best interests.

Staff supported people to eat and drink enough and to gain advice and treatment about this and other aspects of their health and welfare. People had opportunities to engage in activities of interest to them if they wished to do so and felt well enough to participate. Staff encouraged people with this to contribute to people's emotional and social wellbeing.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment practice was not sufficiently robust in the way it was applied and so did not wholly contribute to protecting people from unsuitable staff.

Risks to people's safety were assessed but not always accurately. Staff did not have detailed guidance about how to minimise these risks, although improvements in this area were planned.

Improvements had been made to the safety of systems for managing medicines.

There were enough staff to support people safely at current occupancy levels and staff understood the importance of reporting any suspicions that people were at risk of harm or abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have access to training to support people competently and safely, and training was not updated promptly.

Staff understood the importance of seeking people's permission to deliver care and of acting in their best interests where they were not able to do so.

People received enough to eat and drink to meet their needs and they were supported to maintain their healthcare.

Is the service caring?

Good

The service was caring.

People were supported by staff who had built up compassionate and warm relationships with them.

Staff treated people with respect for their wishes, privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Although records lacked detail about people's needs and preferences, staff understood what these were and how people liked to be supported.

Staff supported people to participate in activities that were of interest to them, provided stimulation and enhanced their wellbeing.

People were confident that the manager would listen to and investigate any complaints or concerns they raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place for checking the quality and safety of the service, although these were not always effective in identifying and driving improvements in a timely way.

People and staff found the manager approachable and were confident their views would be listened to. Staff felt that the service was better organised and managed than it had been and morale was improving.

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

The inspection took place on 24 May 2017 and was unannounced. It was completed by one inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held about the service. This included information about events happening within the service and which the provider or registered manager must tell us about by law.

During the inspection, we spoke with six people using the service and three visitors. We also spoke with the manager and four members of staff including two ancillary staff. We looked around the home, reviewed records relating to the care of four people and medicines records for five people. We also looked at recruitment records for two staff and training records for the staff team. We checked a sample of records associated with the quality and safety of the service, including audits by the provider's representatives and action plans to develop the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this service in July 2016, we found some medicines were not properly accounted for. The audit process did not identify errors promptly so they could be followed up. This was a breach of Regulation 12(1) and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's representatives sent us a plan for making improvements and, at this inspection, we found they had taken action.

People told us that they received their medicines "at about the right time" and staff watched to make sure they took them. Most people told us they knew what their medicines were for, although one person said, "I'm not really sure but I trust them."

During our inspection visit, we observed that the morning medicine round did not finish until approximately 11.15am. However, the nurse on duty felt this would improve as they became more used to the routine. They were aware of people who needed medicines strictly timed because of a health condition such as Parkinson's disease or diabetes; night nurses were involved in giving medicines required early in the morning. The nurse explained they prioritised people who needed more than one dose of the same medicine each day, so doses were properly spaced apart. Staff maintained records with the amounts of medicines given and held in stock so that they were all accounted for when we checked.

The pharmacist supplying medicines to the home recognised that systems for managing medicines had improved. The manager showed us the action plan they had completed the day before our inspection visit, to show how improvements were to continue. This included how they would be following up on the pharmacist's recommendations for best practice.

Although systems for managing medicines had improved since our last inspection, at this inspection we found other aspects of the safety of the service had declined. The safety of the service remained in need of improvement.

Recruitment practice was not sufficiently robust in contributing to protecting people. Both of the recruitment files we checked for newly appointed staff, showed shortfalls in the information required by law and obtained by the service.

One recruitment file showed an unexplained gap of a year and a half for the applicant. One of the staff member's references related to a period of employment 16 years before their appointment. It was unrelated to their more recent work in care services. There was no clear explanation about why they used this referee rather than from their more recent employer in the care sector.

There was an unexplained gap of four years in employment history for the second staff member. Their details referred to them completing mandatory training at another care service. This service was not included in their employment history. We also found a discrepancy, where the reason they gave for leaving a previous post in care was inconsistent with information contained in a reference. There was no evidence of

further exploration with the staff member about the circumstances and to check the information they had provided.

The manager agreed these were oversights in the recruitment process.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, recruitment practices did include checking that nurses' registrations were valid and they did not have any restrictions on their practice. Enhanced checks with the Disclosure and Barring Service were completed before staff started work. This helped to ensure applicants were not barred from working in care services and to reveal any criminal records that may render them unsuitable to work in the service.

Staffing levels were safe for the current occupancy of the service, but there were sometimes delays in responding to people's needs. People told us this was particularly in the morning and after lunch. People said they felt safe but staff arrangements could present problems.

One person said, "Sometimes you have to wait but they might come and let you know they're with someone else. If I need the toilet I usually manage to hang on but not always." Another person commented that, "The staff are very busy and when they are, you just have to wait." Everyone we spoke with said that sometimes they might have to wait for five or six minutes. This was consistent with the findings of our previous inspection.

Staff felt that, although they were very busy, there were enough of them to meet people's needs safely. We noted staff had allocated breaks after lunch, which was one of the times people said they could wait longer for assistance. Staff acknowledged that there could be issues when they took breaks but they would interrupt these to help if necessary.

The manager was aware of the need to keep people's dependency levels under review and to adjust staffing levels if necessary. They had emphasised the importance of this to the service provider in their plans for improvement. Recruitment was ongoing and the manager used agency staff to provide cover when necessary. The manager told us that they had increased night staffing levels to enhance people's safety. They intended to review daytime staffing levels if occupancy levels increased. They had appointed a nurse due to start work shortly after our inspection, who would take the role of clinical lead and deputy manager.

Nursing staff assessed risks to people's safety and welfare such as from not eating and drinking enough, swallowing difficulties and to their skin integrity. As at our last inspection, there was not always sufficient, clear detail for staff about managing these risks. In some cases, the assessed risk was underestimated. This could mean people did not get appropriate staff intervention to manage the risk, particularly given the manager had to use of agency staff from time to time. They may not know people's individual needs as well as permanent staff.

For example, one person's records contained a hospital transfer letter dated March 2017. This showed the risk to the person from pressure ulcers was very high. The person's skin had broken down before they returned to Austhorpe House and so, together with the transfer letter, should have triggered a review of the home's assessment on their return. This had not been updated since January 2017, did not show the increased risk associated with their skin breaking down and showed only that they were, "at risk." It did not reflect their current condition and the need for increased intervention to promote their safety. However, nursing staff at the home were treating the person's wound and monitoring progress towards recovery.

Three people we spoke with said that they found it uncomfortable to use the hoist and that sometimes it hurt them when staff used it. For example, one person said, "I would get up more but the hoist hurts me. I'd rather stay in bed." A fourth person told us, "There's always two [staff] when they use the hoist; I love to go in it. Sometimes it can hurt but I ask them to put me back down and adjust it."

In January 2017, the local clinical commissioning support unit (CSU) checked the service. Their clinical quality and patient safety managers identified a lack of detailed guidance for staff about the equipment needed to move and transfer people. They found a lack of information for staff about the size and type of sling used for each person, and how staff should fix loops to the hoist. The CSU had recommended improvements to the level of detail in staff guidance to improve people's safety and wellbeing. We found these improvements remained outstanding and could potentially contribute to people's discomfort when staff used the equipment if they did not have sufficient guidance.

However, the manager explained how they were allocating staff time to secure improvements to care plans and assessments of risk, as the CSU had advised. The manager was aware of the need to make further improvements and had implemented a more regular system of checks to ensure people's safety. This included regular, recorded checks on people who were in their rooms to make sure they were positioned safely, supported to change position if they needed to, and that they had a drink to hand.

Some routine management of risks within the environment had slipped. For example, we found portable electrical items that were overdue for testing. Staff used five of these regularly for hairdressing and could not be sure they remained safe to use. They were not tested in January 2017, as they should have been. The manager undertook to address this with maintenance staff promptly to ensure neither people using the service nor staff were at risk when they used the equipment.

Staff received training to help them respond to an emergency such as a fire. One staff member newly in post confirmed they were shown fire exits, emergency call points and the fire panel during their induction. They had not yet participated in formal fire training or a drill but had not been working in the service for long enough. Information the manager provided to us showed that there were gaps in both training in fire safety and in evacuation practice as well as in first aid. This could compromise how confidently staff would respond in the event of an emergency or accident to promote people's safety.

The service provider had invested in the home's plumbing and water storage systems to address concerns about legionella risks. They were in regular contact with the Health and Safety Executive (HSE) who followed up the concerns we referred to them following our last inspection visit. Some work was completed and was continuing at the time of our inspection visit. The service provider had trained two members of maintenance staff in basic legionella management to support improvements in this area.

Other improvements to people's safety requiring investment, such as a proposed upgrade to the call bell system, had not taken place. There were still some risks, depending on where people were spending their time in the home or garden, that they would not be able to summon assistance easily when they needed it. Staff were aware of these. They maintained regular checks on people using the conservatory where there was only one call bell point, or if they wanted to sit in the garden.

There were measures in place to help protect people from abuse. One person told us, "I've been here years, they look after me very well and I do feel safe, I've nothing further to add." Another person said, "I have had falls but not recently, I feel safe because there's people here to look after me." A visitor told us about care for their family member. They said, "Yes [person] is safe, I have no concerns and I've been assured [person] is well looked after."

Staff were able to explain to us the signs there might be that a person was at risk of harm or abuse. They were clear about their obligations to report their suspicions so that they were followed up and investigated properly. The manager was able to account for the action she would take to report concerns to the local safeguarding team and to cooperate with investigations.

Requires Improvement

Is the service effective?

Our findings

At the last inspection of this service in July 2016, we rated the effectiveness of the service as good. At this inspection, we found that the effectiveness of the service required improvement. There were increasing numbers of gaps in the training staff required to ensure they remained competent in their roles. The training schedule showed how often the service provider intended that staff should renew their training. This had not happened in a timely way and in accordance with their intentions. This presented a risk that staff would not support people effectively or be up to date with best practice.

People and their visitors told us that they felt staff were competent in their roles. For example, one person told us, "I think they know what they're doing." Staff also said they had access to training although they were able to identify some gaps. One staff member told us some of their training might be out of date.

Quality and safety managers from the local commissioning support unit (CSU) completed an audit in January 2017. This too identified that training for staff was overdue. They also identified gaps in clinical training and development for registered nurses. This included training in diabetes care, catheterisation, venepuncture and management of syringe drivers. One nurse told us that they had not had any recent training to manage syringe drivers.

We confirmed shortfalls in training from the incoming manager's training records. Some staff training in core areas was overdue based on the expiry dates recorded. For example, we found that, two staff members had not renewed their first aid training since 2011. They were supposed to receive updates every three years. Three staff were more than a year overdue to renew their training in moving and handling people based on the training record and the service provider's expected renewal dates.

One person using the service for a number of years and receiving palliative care had a grade four pressure ulcer they acquired before moving to the home. Nursing interventions had been successful in preventing the wound from getting worse. However, some nursing staff had not received training in pressure ulcers. The former manager explained to the CSU that nursing staff could only access tissue viability training if the service provider funded it. This had not happened and meant that the nursing team might not be up to date in best practice and current techniques for treating pressure ulcers. One nursing staff member did say that they would welcome this training, as they knew that techniques for treatment moved on and they had not had any recent training.

The service advertises, on a sign outside the home, that it offers palliative care. Although four of the 25 staff listed were only appointed during 2017, a total of fourteen staff were without dates to show they had completed this training at all. It was supposed to be renewed annually, based on the training schedule. Only two staff had training that had not yet expired. Two staff had not received updates for up to ten years.

There was a risk, because of gaps in training and lack of prompt renewal, that people would not receive effective support with all their care needs.

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

The incoming manager was aware of shortfalls in training that had developed before their appointment and had been checking priorities for its renewal. They had secured some training materials for care staff, including DVDs and had discussed people's needs during staff meetings. The manager was anticipating that the appointment of a new nurse as a clinical lead would help to update practice of both care and nursing staff. They confirmed that their intention to discuss with the provider's representatives that it would be useful for some staff to attend "Train the Trainer" courses in specific subjects. This would enable them to train other members of the staff team in those subjects and contribute to staff being able to update their training in a more timely way.

The manager and new staff confirmed that new staff shadowed those who were more experienced so that they were able to learn about the support people needed. Staff said that they felt well supported by both the incoming manager and colleagues. They said that there were staff meetings to help keep them up to date. There were opportunities for staff to receive support through supervision. The manager had a schedule for ensuring that this was improved. They confirmed to us that they would be seeking training for senior staff in supervision skills so that they could delegate this task and sustain arrangements.

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

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

People told us that staff asked for their permission before delivering care to them. For example, one person said, "They always come and ask me if I want a bath." Relatives felt that they were involved in important decisions about people's care if they wanted to be. We also observed that staff asked people if they needed any help.

Although overdue for renewal in some cases, all staff in post longer than six months, including ancillary staff, had received training in the MCA so that they would understand their legal obligations. Staff we spoke with understood the principles of the MCA. They told us how they respected people's decisions about whether or not to receive care. They took into account whether the person understood essential aspects of their care, for example to manage continence. They said that they would ask the person's permission and explain what they needed to do. If the person refused they would check the person was safe and then they, or a colleague would go back to offer support slightly later. They understood the importance of acting in the best interests of people who found it difficult to give informed consent to specific aspects of their care. However, this was not always well represented and assessed in care plans.

The manager was aware of the need to consider the least restrictive options to ensure people's safety. They understood when they would need to make an application in accordance with DoLS if it was essential and a person could not make informed decisions about risks to their welfare.

People had a choice of enough to eat and drink to meet their needs. One person told us, "We have the choice of two meals at lunchtime. They come and ask the day before I think. I like the food, there's plenty and it's tasty." Another person said, "The food is very good, I get enough to drink." One person needed a particular diet to avoid gluten. Their visitor told us, "I've brought fruit in today but they [staff] are really good. They make him gluten free cakes such as brownies so he doesn't miss out."

A member of the catering staff showed us how they made batches of food such as cake or scones, freezing them in suitable portions so that the person always had choices. They had a detailed list of ingredients and condiments they must not use and were able to tell us confidently about meal preparation for this person.

Staff monitored people's weights to see if a person experienced any unintended weight change. People's care plans lacked clear guidance for staff about using alternative measurements for people who could not use the scales. They did not properly reference when and how staff would need to take action in response to specific concerns. However, staff had recognised sought advice about one person's weight and nutrition. They referred the person to the dietician for advice and their visitor was aware of concerns. They told us about care for their family member saying, "We've talked about what might be happening and he's going to see a dietary specialist. Staff have been trying to increase his food intake but he struggles to eat. What is useful is they write down how much he's had [to eat and drink] so we can check."

A catering staff member told us they knew which people needed to increase their calorific intake because of concerns about their eating or weight. They were able to describe to us what they did to fortify foods to help support people's welfare if they were losing weight. They also knew who needed their food prepared in a particular way because of swallowing difficulties.

We saw that care staff provided people with support to eat their meals if they needed it. They sat down alongside people to offer assistance or encouragement, chatting to them during the meal. The mealtime was relaxed and unhurried. Notice boards displayed information such as lunch menus for the current and following week, a breakfast menu and information about what to do if people using the service wanted a snack or drink at any other time than set meal times. In each bedroom we checked, people had a jug of water and bottle of squash. They had a tumbler of water or squash within reach.

People received support to seek advice from health professionals outside the home when they needed it. One person told us that, if they became unwell, "I'd ring the bell and ask to see the nurse on duty." They were confident that staff would contact their doctor if they were unwell. The manager felt that relationships with the GP surgery were good and that they could get advice when they needed to.

People told us they could also have advice and support with foot care. One person said, "I think a chiropodist comes every five or six weeks but they (care home staff) can call them out if you need to see someone between visits." People could also see the optician and dietician.

We noted from records that staff monitored people's health conditions, recording and acting on the advice that healthcare professionals gave to them. They also handed over information between shifts so that they knew if anyone was unwell and required additional monitoring or support.

Good

Is the service caring?

Our findings

At the last inspection of this service in July 2016, we found that people experienced a caring service and rated this aspect of the service as good. At this inspection, we found the service continued as caring. All of the people and relatives we spoke with told us the staff were kind and caring and that they enhanced their wellbeing.

People and their visitors said that they felt staff knew them well. They understood how people wanted to be supported and interacted with them in a warm and kindly manner. One person said, "They [staff] know me. They know I don't like cheese so if there's something on the menu with cheese in, they know to make me something else." Another person commented, "I get on with the staff really well, they're always smiling." A third person told us, "They [staff] treat me alright, they're friendly."

A visitor to the service told us how much they had valued the approach of staff. They said, "I volunteer because my [family member] was here until he passed away about two years ago. I like to come in to help because they looked after him so well and helped me too. They gave me support when I needed it." We also noted that a written compliment to the service thanked staff for "…most excellent care, friendship, stimulation and much laughter. [Person] had the utmost trust in staff." Another written compliment made just before our inspection said, "Your care and love has been overwhelming."

Another visitor said that staff related well to people. They told us, "What I like is that the carers do sometimes find time for a quick chat. Yesterday I needed to leave [person] on her own for a bit. When I got back I found a staff member sitting and chatting with her." A third visitor who went regularly to the home said, "I don't ever tell them when I'm going to visit so if anything was wrong I probably would know by now."

During the course of our inspection visit, we saw many examples of staff talking with people in a friendly manner and greeting people with a smile. We heard chatter and laughter between staff and people living in the home, contributing to a happy atmosphere.

Staff treated people with respect for their privacy and dignity. One person said, "Most knock or ask to come in. Usually I have my door open so I can see what's happening, I like to watch them coming and going." We observed, with only one exception, that staff either knocked on people's doors or spoke with them from the doorway before entering their bedrooms.

Staff closed people's bedroom doors when they were providing personal care. A visitor to the service spoke to us about staff saying, "They do [respect people's privacy]. When they're doing personal care, like washing [family member], they ask me to wait outside. I looked after him before he came here but I think they are treating him with respect." We heard staff explaining to people what was happening when they went to assist them, for example, when they were using the hoist.

People were able to make their rooms homely by bringing in belongings and mementoes. One person told us, "Most of the furniture came from my house, because this is my home now." People were also able to see

their friends or family at any time. One person told us, "My [family member] comes to visit often and whenever he likes." A visitor told us how staff had supported them to celebrate a special occasion with their family member who lived at the home. They said, "We've celebrated our 50th wedding anniversary since [person] has been here. We had a small party and it was really good. The staff helped us."

People's care plans did not always record the involvement of the person or others who had significant knowledge of their histories and preferences when they were well. However, people told us they were able to make decisions about their care. A visitor to the home told us, "The staff talk to me about [family member's] care; they asked me what he likes and what he doesn't."

Staff had built up relationships with visitors to the service, from whom they could gather further information if people could not provide this themselves. Visitors told us that staff kept them informed of any changes in their family member's health or wellbeing.

The core of long-standing staff members had developed an understanding of each person. This included understanding how people, who could find it difficult to express their views verbally, showed they were in discomfort or distressed. This enabled staff to offer reassurance and to anticipate the care people needed.

We saw that staff offered people choices throughout our inspection. This included checking whether they needed help, what they wanted to do and about meals. The staff member responsible for arranging activities spoke to people during our visit to see whether they wanted to join in an activity and wanted any assistance to get there. The staff we spoke with demonstrated they understood the importance of offering people choice and supporting them to make decisions for themselves.

Good

Is the service responsive?

Our findings

At our last inspection of this service in July 2016, we found that people received a service that was responsive to their needs. At this inspection, we found that, although records showing people's care needs lacked detail, staff continued to understand people's preferences and worked to support them as individuals.

People felt that staff understood their preferred routines. They recognised there were sometimes constraints, particularly in the morning, if several people needed assistance at the same time. For example, one person told us, "I'm used to getting up quite early but I have to wait because I need help. It's different in the evening, I can choose when I go to bed." A visitor to the home commented how staff responded to individual needs. "I think so [staff understand individual needs]. Everyone here has different problems but the staff know them." Another regular visitor felt staff treated people as individuals. They told us, "I think they do, for example [family member] often likes to go to bed in the afternoon and that isn't a problem."

Staff agreed that there were busy times when they were not always able to support people promptly at their chosen time. However, they described to us how they would check whether people were ready to get up and if they were not, would move on to assist someone who wanted support at that time. Staff felt that they shared information well about the support each person required. This included discussions at hand over about how people were and whether there were any changes indicating staff needed to increase their monitoring of people's welfare.

There were regular activities people could engage in if they wished. One person told us, "I do sometimes get bored but there's not much that can be done about that. I do watch my television but I miss going out." The person explained that they had enjoyed outings in the past but their health had declined so they were not able to join in as much. Another person said, "We have gone to the pub across the road. A few of us have been taken over there and had a meal, it was quite nice."

There was an activities coordinator in post who knew people well and what they were interested in. They told us, "I did arrange some trips last year but most people here now are not well enough for that sort of thing, I am taking two gentlemen out next week, I've arranged a taxi but it's quite expensive. Last year we booked a minibus which worked out much less per person, and we had it for the whole day." They were in the process of organising a summer fete so that they could raise additional funds to help with such activities.

During the afternoon of our inspection, an accordion player and singer provided entertainment for people in the conservatory. We saw that this was well attended and that people sang along with the tunes.

We asked people whether they felt the service supported them with their spiritual or religious needs. Two people told us how they used to go to church, but they were happy with the arrangements within the home at this time. One person said, "I think they have a service once a month but I don't feel the need to go." Another person told us, "I am sure there's a vicar comes in. I'm not sure how often but I don't need it, it's in me, in here." The person pointed to her heart.

Visitors said that they knew how to complain and would go to the manager if they needed to raise any concerns. They knew who the manager was and thought that the manager would take action to improve in response to their concerns. We saw that people had access to information about how to make a complaint and what they could expect if they did. This was contained in a folder on the front table in the main hall but needed updating to reflect the change in management arrangements.

One visitor told us that they had needed to raise concerns about how staff used a thickener for drinks, as they had not always mixed it properly to the right consistency for the person. They said, "I did need to mention it a number of times but the situation has improved and I think they mix it to the right consistency now." They felt that their complaint had been resolved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of this service in July 2016, we found that leadership and management of the home needed to improve. At this inspection, the service still needed to make improvements.

The provider had increased their representatives' visits to monitor and check the service and needed to maintain this to ensure they initiated and drove further improvements. However, the monitoring and auditing systems in place had not identified slippages that we found during our inspection, for example in recruitment practices and maintenance checks. We raised our concerns with the manager that progress towards improving the quality of the service was disappointingly slow.

Some improvements the provider's representatives had identified as necessary in their audits, or told us about in their action plan following the last inspection, had not been made. This included training, further review of care plans, and a satisfactory application to vary registration conditions.

At our last inspection, we noted there were two applications to the Care Quality Commission (CQC) to vary a condition to reduce the numbers of people the providers could accommodate. They made these applications during 2015 but CQC had to reject them, as they were incomplete or inaccurate. Neither the service provider nor the previous registered manager had taken action to make an accurate and complete application reflective of their intentions and their Statement of Purpose.

Since our last inspection in July 2016, the previous registered manager had left the home. The service provider had appointed a new manager who completed an induction period with the outgoing manager. They had only been working at the home in full managerial capacity for three weeks by the time this inspection took place. The manager demonstrated an understanding of the shortfalls within the service in their discussions with us. They explained their priority was to improve recruitment so that the reliance of the service upon agency staff would decrease. This included the successful recruitment, pending employment checks, of a deputy manager. This would help provide more clinical support to nursing staff and strengthen the management of the home.

Unlike the previous registered manager, the incoming manager was not covering nursing shifts. This allowed them to focus more on the operation and development of the service. We saw that they had liaised with the provider's representatives about ongoing improvements and agreed revised timescales for making these. We acknowledged that their short time in post meant they had not been able to address all areas of concern.

Shortfalls in care plans were recognised in the provider's audits of the service in both October 2016 and early in April 2017 but improvements had not yet been made. Although there were potential risks to people's welfare arising from the lack of detail in their records, these were mitigated because of a core of long-standing care staff members with a good understanding of people's needs. However, there was a risk to people using the service if staff turnover increased and new staff currently being appointed had poor information to refer to. The manager said that they were allocating staff time to updating and improving

people's records and putting these onto an electronic system so they would be easier to monitor and update.

The manager had introduced a more structured system for checking the welfare of individuals on a day-to-day basis, particularly those cared for in bed. As part of this, there was a "skin condition record" for staff to complete when they assisted people with personal care. However, possibly because this was a new system, the records did not show that staff had a clear understanding of how to use them. The records did not show completed checks on the person's skin condition during the delivery of personal care to help identify concerns for skin integrity at an early stage. We discussed with the manager the need to clarify further with staff, the purpose of the records they had introduced.

In response to an external audit by quality and safety managers from the local commissioning support unit (CSU) in January 2017, the incoming manager had put an action plan together for addressing their concerns. They were providing updates to the CSU about their progress. This included working towards better practices for controlling the risk of infection. The manager had drafted a job description with additional information for the role of a lead staff member in infection prevention and control. They had not yet confirmed a staff member in that role so that they could ensure they made the relevant training available. Clinical training needs for nurses also needed assessing and following up.

People using the service said they could not remember being consulted for their views about it, either in a questionnaire or in meetings. We asked the manager about formal consultation to enable people or their visitors to express their views as there had been a system in place when we last inspected. They told us they had not been able to locate the outcome of any recent surveys where people given their views about how the service could improve or change. This meant they were not sure whether people had suggested any improvements or whether there was an action plan for them to follow.

However, there had been a "Friends of Austhorpe House" meeting, which the incoming manager held in early May 2017. This enabled visitors and people using the service to express their views. The minutes recorded the agreement to meet on a quarterly basis to discuss the service.

The manager showed us the surveys staff completed in November 2016, after our last inspection and before the current manager took up their post. These contained expressions of concern, such as whether the company was a good employer, for teamwork, common goals and morale. The manager was not able to locate an action plan from the provider's representatives or the former manager, to respond to the results. However, staff and people using the service responded positively to us about the change in leadership of the home.

People using the service and their visitors, were aware that management arrangements had changed. They told us that they felt the home was well managed. They knew who the incoming manager was. A visitor told us that the manager had introduced herself to people so they knew who she was. They said, "The manager is quite new, she's only been here a few weeks but you see her around. She talks to residents and I think she's very approachable."

Staff told us that they felt that the incoming manager was more organised in the way she operated the home. For example, one told us, "We had a recent staff meeting. It was information sharing for the manager, telling us how she would like things. She speaks sense and it had got a bit laid back so it needed a kick." Another commented that they thought the change was positive and, "It's good to have some fresh eyes on things." They felt the manager was approachable for advice and receptive to their views.

All of the people or visitors we spoke with agreed that they would recommend the service to a friend or family member. For example, one person told us, "It's good. I don't think there can be many better places round here." The staff team had received many written compliments from visitors about care for their family members. These showed a high degree of satisfaction with the service. Staff spoken with told us that they would be happy for a family member of theirs to be cared for in the service.

The incoming manager had not yet registered with CQC, as they were newly in post. However, they stated their intention to do so. They were able to tell us about the responsibilities of a registered manager, including the notifications they must make to CQC about events taking place in the service. They were able to answer our questions about a notification made by the previous manager. They explained the action they were now taking to follow it up. We found that the manager had a good understanding of their role and a vision for what needed to improve. Management arrangements, with ongoing support from the provider's representatives, needed to consolidate to make and sustain improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operating effectively to check the suitability and fitness of staff appointed in all regards and to ensure the required information about those appointed was obtained. Regulation 19(1)(a), (2) and (3) and Schedule 3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had not ensured that staff were suitably competent and skilled to support people. Staff had not received the appropriate training and professional development they needed to enable them to carry out their duties and, where they were nursing staff, to update their clinical skills and expertise. Regulation 18(1), 2(a) and (c)