Buckland Care Limited

Merry Hall Nursing & Residential Care 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 4 and 5 October 2016 and was unannounced.

Merry Hall Nursing & Residential Care Home is a registered care home and provides accommodation, support and nursing care for up to 32 people, some of whom live with dementia. Support is provided in a large home that is across four floors. Communal areas include two lounges and a dining room. At the time of our inspection there were 24 people living at the home.

Following an inspection in February 2016 the Commission served one warning notice for failing to ensure effective and safe recruitment processes. Due to concerns about the safe care and treatment of people, person centred care and governance the Commission also imposed a condition on the provider's registration that required them to audit all people's care plans, risk assessments and medicines on a weekly basis and produce a monthly report for the Commission regarding this. In addition to the warning notice and the imposed condition, requirement notices were issued for failure to ensure safeguarding of people, appropriate numbers of skilled and trained staff, ensuring appropriate consent was sought, ensuring complaints were responded to and for a failure to ensure people were treated with dignity and respect.

At the last comprehensive inspection in February 2016 this provider was placed into special measures by CQC. This inspection found that insufficient improvements had been made to take the provider out of special measures as they were still rated inadequate in one key question.

There was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A person had been employed to be the registered manager and had started their application process with the Commission. They had only been working as the manager for one week at the time of our inspection.

After the previous inspection in February 2016, we imposed the condition to support and ensure the provider assessed aspects of the service which could pose a risk to people and take appropriate action. However, we were not confident in the systems the provider used to assess these areas as the information the Commission had been provided with as a result of this condition, we found to be inaccurate and not reflective of our findings during this inspection.
Quality assurance systems whilst in place were not fully effective in identifying and remedying shortfalls in a number of key areas.

Some improvements had been made to the management of medicines however despite weekly audits, medicines were not always managed safely. Gaps in recording of the administration of medicines had not been identified and explored and medicines had not been administered despite records saying they had. This had not been identified prior to our inspection.

Some improvements had been made to the recruitment of staff, however these were inconsistent. Appropriate recruitment checks had not always been undertaken and the provider's policy was not always adhered to. Whilst audits had identified concerns with recruitment records of staff, this had not driven the improvement needed.

Some improvements had been made to the assessment and management of risk associated with peoples care although further work was needed. Care plans had improved although where we found gaps and inconsistencies, the providers weekly audits had not.

People raised concerns about staffing levels and our observations reflected that these did not always meet people's needs. The deployment of staff did not always ensure suitably skilled and trained staff were on duty because staff had not always received appropriate training, induction and supervision.

Day to day people's choices were met but the service continued to seek consent from people who did not have the legal authority to provide this. At times capacity assessments were not decision and time specific and best interests decisions could not always be demonstrated. Deprivation of Liberty safeguards was mostly understood and authorised applications were held in people's care plan folders. We were concerned that one member of staff told us if a person with capacity to make the decision wanted to go out, they would not allow them to go out alone.

Whilst staff did not always understand the term safeguarding, they knew the signs of abuse and the action they should take if they had any concerns abuse may be occurring. We have made a recommendation that the provider review the system used to identify matters that require reporting to the local authority safeguarding team to ensure these are recognised and acted upon promptly.

People's nutritional needs were met and they described the food as good. Complaints were acted upon and addressed.

People felt staff were kind and caring. Staff demonstrated how they respected people's privacy and dignity. They spoke kindly and offered support when needed. Staff had a good understanding of people, their needs, likes and preferences.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is now considering the appropriate regulatory response to the shortfalls we identified during this and previous inspections. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take. You can see what action we told the provider to take at the back of the full version of this 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.

Medicines were not always managed safely.

Appropriate pre recruitment checks had not always been undertaken and the provider's policy was not always adhered to. Staffing levels did not always meet people's needs.

Staff knew the signs of abuse and the action they should take if they had any concerns abuse may be occurring. We have made a recommendation about this.

Some improvements had been made to the assessment and management of risk associated with peoples care although further work was needed to embed this.

Is the service effective?

Requires Improvement

The service was not always effective.

The deployment of staff did not always ensure suitably skilled and trained staff were on duty because staff had not always received training, induction and supervision.

Staff understanding of the mental capacity act had improved and the day to day decision's people made were respected but the service continued to seek consent from people who did not have the legal authority to provide this. At times capacity assessments were not decision and time specific and best interest decisions could not always be demonstrated.

People's nutritional needs were met and they had access to other external health professionals as the needed it.

Is the service caring?

Good

The service was caring.

People felt staff were kind and caring.

Staff demonstrated how they respected people's privacy and

dignity. They spoke kindly and recognised when people needed support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had improved although further work was needed to ensure records were accurate and up to date.

Staff had a good understanding of people, their needs, likes and preferences.

Complaints were acted upon and addressed.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor quality remained ineffective in driving improvements and records were not always accurate.

The home did not have a registered manager. The manager and deputy manager were new in their role. Staff felt supported by the manager who operated an open door policy and encouraged suggestions.

Merry Hall Nursing & Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 5 October 2016 and was unannounced.

The inspection team consisted of an inspector, a specialist nursing advisor 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 information we had about the service, including previous inspection reports and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law. We also received feedback from the local authority.

During the inspection we spoke with 13 people who lived at the home and four visitors. We observed the care and support people received in the shared areas of the home. We spoke with the manager, the manager's line manager and eight staff including nurses, care staff and ancillary and activity staff.

We looked in detail at the care plans and associated records of five people and sampled a further four people's records. We looked at medicines administration records for 14 people who lived at the home, staff duty rotas, and nine staff recruitment and supervision records. We looked at staff training records, records of complaints, accidents and incidents, meeting minutes, policies and procedures, safeguarding and quality assurance records.

We requested information was sent to us following the inspection and we received this.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and were happy living at the home. However, one person expressed a sense of having to wait and were empathetic to staff's workloads. They said "I can wait 40 minutes, it can be tardy". They said this can be uncomfortable when they need to use the toilet but then said "they [staff] do their best".

At our inspection in February 2016 we found the registered person had not ensured risks associated with people's care were effectively assessed and managed. Prompt and effective action had not been taken following injuries to prevent the risk of further injuries occurring. Where people displayed behaviours which presented a risk these had not been risk assessed or plans developed to reduce the risks. The management of medicines was not safe. Errors had occurred and were not known by the manager, prescriptions were not followed and records relating to the disposal of medicines were not clear. This was a breach of Regulation 12 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014. This breach informed the imposed condition on the provider's registration.

At this inspection some improvements had been made to the management of medicines. Medicines were stored safely. Trolleys were locked and the temperatures of medicine storage was held. Allergy information was recorded. The disposal of medicines had improved and the records were clearer. Action had been taken following our last inspection to ensure the storage of controlled medicines was safe. Registered nurses had received competency assessments of their ability to administer medicines.

However, we also found that the management of medicines was not always safe. We noted that at times medicines errors had had occurred. Some of these been reported appropriately and action taken to address them. However, we reviewed the medicines administration records (MAR) for 14 people living in the home and compared this to the stock held. Between the 11 September and the date of our inspection we found that three people had medicines signed as being administered but the tablet(s) remained within the blister pack. This had not been identified as a medicines error. We spoke to a nurse about this who was unable to clarify what had occurred. When we raised this with the manager they were unaware of these errors. As such no investigation as to why this had occurred had taken place. In addition gaps in the recording of the administration of medicines were found in eleven people's MAR with no explanation as to the reasons for the gaps in the records. Where people were prescribed creams these were not held safely. Six people's creams stored in their rooms were either not named, not dated when they had been opened and one person's was out of date. Following our inspection visit we referred concerns about the management of medicines to the Local Authority responsible for safeguarding. The sent us a copy of the action plan they had received from the service. This detailed how they would undertake medication audits twice daily between two competent staff members to prevent future occurrences.

The manager told us that two senior carers also administered medicines in the home. We saw that their competency to do this had been assessed. Whilst these two senior carers had received a competency assessment and they had received training in the past, records showed they had not attended any medicines training to refresh their knowledge since starting work at the home.

The failure to ensure the safe management of medicines was an ongoing breach of Regulation 12 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014. Whilst we continued to find concerns with the providers compliance with Regulation 12 the condition imposed by the Commission requires them to take weekly action to make the improvements needed and ensure this regulation is met. The Commission considered this condition remained appropriate.

At our inspection in February 2016 we found the registered person had failed to ensure appropriate recruitment checks were received prior to staff commencing work. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served warning notices requiring the provider to be compliant with the regulation by 31 March 2016.

At this inspection we found some improvements had been made to the recruitment of staff, however these were inconsistent. The provider's policy provided clear guidance about the recruitment of staff. This stated that "Only applications made using the proper form are considered, Interviews are not conducted until a completed application form has been received.... The assessments made by interviewers must be formally recorded on an interview assessment form... A minimum of two written references, one of which will be from the applicant's most recent employer, are obtained after a job offer, but before an appointment is confirmed and the person is allowed to commence work... All new staff are confirmed in post following completion of a satisfactory criminal records enhanced or standard check".

Of the nine staff recruitment records we looked at we found that Disclosure and Barring Service (DBS) checks had taken place for all staff prior to them starting work. However for three staff the provider's policy had not been followed and we were not assured of safe recruitment processes being undertaken. The manager told us that one member of staff had been employed on the providers bank team and recruitment records from 2012 were available for this person. However the manager told us they thought the staff member had not worked in the home since 2014 and they had been working for another company. This person had started working again at Merry Hall Nursing and Residential Home the day before our inspection however, no new application form had been completed, no record of a recent interview having taken place was available and no references had been requested or received prior to them starting work in October 2016. The manager confirmed they knew this staff member on a personal level and had not completed the recruitment process laid out by the provider's policy because they had had been employed on the bank team. For a second member of staff we found no application form, no record of interview and no record of health checks having taken place. The manager confirmed this person came from a recruitment agency and as such they had not followed the provider's policy. Whilst this person may have been introduced to the service by a recruitment agency the registered person is required to ensure recruitment processes are safe for all staff they employ. For a third member of staff we found no record of an interview having been undertaken and no record of references being sought before they commenced work. The manager could not explain why there were no references for this person.

The continued failure to ensure safer recruitment processes of all staff was an ongoing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in February 2016 we found the registered person had not ensured staffing levels were sufficient to meet people's needs and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us that the provider would be compliant with the regulation by 29 May 2016.

At times we saw that staffing levels were not sufficient to meet people's needs. One person expressed how they needed to wait for extended periods of time. They said "I'm waiting and waiting in the morning and

evening", then said "they do their best", referring to staff. In addition records of meetings held with people living in the home demonstrated another person was concerned about the staffing levels. For example, the meeting dated 3 October 2016 recorded that this other person had said "night carers? Need more on the floor".

The handover sheet showed that seven people required support with their meals. The manager confirmed that the staffing levels supplied were one nurse and 6 care staff in the morning, 1 nurse and 4 care staff in the afternoon and 1 nurse and 3 care staff overnight. At meal time we saw nurses completed the medicines round leaving care staff to support people. This meant some people had to wait for their meals or support if staff were busy helping others. Staff told us that they generally felt there were enough staff on duty but then also told us how it was difficult during the afternoons when the staffing levels dropped. One nurse told us they felt more nurses were needed as one was not enough. A care worker told us that in the afternoon they cannot always respond to calls when people need support to eat their meals as they don't have enough staff.

We observed that generally calls alarms were responded to promptly and when people required support in communal areas and staff were available they got support quickly.

However, on the first day of our inspection we saw one person lying in their bed, requiring support. We pressed the call bell and a staff member responded promptly. However, they required the assistance of a second member of staff which they requested via the call bell. No one responded to this and the staff member was required to go and find support. It was 10 minutes after we called that the person received the support they needed.

The manager's line manager told us that they had discovered after our last inspection that staff had been silencing people's call alarms from the main call point without going to people's rooms. They told us they had raised this with staff and believed this practice had stopped. However, on the second day of our visit we observed a person press their call alarm for support. This alarm then appeared to turn off without staff entering the person's room. The person pressed the call bell again and staff responded 14 minutes after the person first called for support. The manager's line manager told us they would have the ability to turn call alarms off without entering people's rooms removed from the system.

At this inspection the provider had introduced a new staffing dependency assessment tool. The manager told us they planned the rotas and then inputted the levels of people's needs and the planned rota hours into the dependency assessment to determine if the planned rota was sufficient. They told us they planned the rotas and inputted the information into the dependency assessment two weeks in advance to determine if the planned rota was sufficient. However they confirmed they had not done this since the week ending 2 October 2016 as they had IT issues. Whilst this tool showed them if they were delivering within an average range of hours the manager was unable to tell us how they used this to deploy staff and determine that four care staff was sufficient in the afternoon. The manager's line manager told us the change between the afternoon and morning was due to people needing less support in the afternoon. The manager and their line manager told us that they would increase the staffing levels in the afternoon to six care staff. Following our inspection visit we referred our concerns about the staffing levels to the Local Authority responsible for safeguarding. They sent us a copy of the action plan they had received from the service. This detailed how they would ensure the dependency tool was completed weekly and that the staffing levels in the afternoon had increased.

The failure to ensure enough staff at all times to meet people's needs was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008.

At our inspection in February 2016 we found the registered person had not reported safeguarding concerns appropriately and this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us that the provider would ensure vigilance in reporting any safeguarding concerns. They said they would be compliant with the regulation by 29 April 2016. At this inspection improvements had been made and they were no longer in breach of the regulation.

At our last inspection we found the registered person was not reporting serious unexplained injuries appropriately and investigations into serious unexplained injuries were not being carried out. Since our last inspection we saw that a number of safeguarding referrals had been made by staff to the local authority relating to medicines errors which had been investigated and appropriate action taken. However, we also found an entry in one person's daily records detailing a large bruise. The manager told us the family and GP had been informed, although no records were available to confirm this. The manager confirmed this was unexplained and that a safeguarding referral was not made. We referred this to the local authority (LA) safeguarding team. Following the inspection visit the manager told us how they had involved the GP again who was undertaking tests to identify if there may be an underlying cause to bruising for this person.

Staff spoken to could not tell us what the term safeguarding meant, however they could tell us about the different types of abuse, how they might recognise this and the action they would take if they had any concerns. They all said they would raise concerns with the manager who they felt confident would take appropriate action. They all said if they felt their concerns had not been listened to or taken seriously they would report their concerns to the local authority or police.

We recommend the provider review the system used to identify matters that require reporting to the LA safeguarding team to ensure these are recognised and acted upon promptly.

At our last inspection in February 2016 we saw that the assessment and management of risks associated with people's care was not effective or safe. Aspects of this had improved at this inspection and whilst we judged this was no longer a breach, further work was required to ensure the improvements were consistent and embedded into every day practice.

We saw improvements that had been made. Accident records showed that a one person had fallen from bed on a number of occasions. As such discussions had taken place with them about the use of bed rails. The person had agreed to this and we saw they were being used. The care records had been updated to reflect this. For a second person whose health condition posed a risk to them, a clear assessment of this risk had been completed and a plan of care developed. This included the signs and symptoms staff should monitor for and the action registered nurses should take. Input had been sought from external health care professionals to manage this condition safely. For a third person their nutrition care plan detailed the need for staff to thicken their fluids. The manager told us they had been concerned that this person was choking on fluids and contacted the Speech and Language Therapist (SALT) who provided instructions to thicken the person's fluid. The manager could not find any records of this but staff confirmed that this was the support they were providing.

However, for a fourth person we saw records which indicated they displayed behaviours which presented a risk to them and to others. Records from external professionals recorded physical behaviours this person could display towards staff whilst receiving support with personal care, eating their meals and while staff support with their mobility needs. However, an assessment of the risk of these behaviours had not been completed and no plan of care had been developed to guide staff about how to prevent the behaviours occurring or manage them if they did occur. Staff told us how they supported this person and left them to

calm however the lack of clear guidance left the management of these behaviours open to personal interpretation by support staff which could place them and the person at risk.

For a fifth who was eating their meal in their room, we observed that they began to cough and spit food into a tissue. Following this they said "Something in my food is making me choke". They were given a meal of normal consistency, by care staff and prepared by kitchen staff. This person's care plan stated that they should be receiving a soft diet. We discussed this with the manager who agreed this should not have happened. Following the inspection the manager confirmed that at the time of the inspection, the kitchen staff had accurate information that this person should be receiving a soft diet. They told us of the action taken since we raised this with them which included, raising staff awareness of the need to follow care plans. They had also contacted the speech and language therapist (SALT) who had recommended they trial normal foods but following consultation with the person, they had chosen to continue having a soft diet. In addition, they confirmed that a clear risk assessment had been implemented. This subsequent action reduced the risk of this reoccurring.

Requires Improvement

Is the service effective?

Our findings

People told us the food in the home was good. They talked to us about how they made their own decisions and choices. Relatives confirmed this. One told us how they felt staff understood them and their needs.

At our inspection in February 2016 we found the registered person had not ensured consent was sought appropriately and the Mental Capacity Act 2005 was applied correctly. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us that the provider would be compliant with the regulation by 29 May 2016.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection whilst elements of this had improved slightly this was not consistent. At our last inspection we were concerned that relatives had signed consent forms and the service did not have evidence of Lasting Power Of Attorney (LPOA) for health and welfare conditions.

At this inspection we saw some improvements had been made. For one person their care plans contained some information about their ability to make decisions. The "Consent for care and treatment" form was signed by the relative whom the manager told us was very involved in this person's care. Records were held confirming this relative had power of attorney for health and welfare. Mental Capacity assessments were also in place regarding the use of bed rails, personal hygiene and medication. For a second person they had been asked to provide consent to use a specific piece of equipment before this was used. Throughout the inspection we observed people being given choices about where they wanted to spend their time and what they wanted to eat and drink. Their decisions were respected. For example, one person wanted an alcoholic beverage and they were given this. A second person told us if they wanted to sleep all day they could.

Whilst attempts had been made to comply with the MCA, these were not always time and decision specific and best interest discussions and decisions did not always follow the assessments. For example, for two people, mental capacity assessments had been completed and asked if the person could consent to care and treatment. This deemed they lacked capacity and stated staff should make decisions in the person's best interests. No best interest decision was recorded. Consent to care and treatment can cover a wide range of decisions including simple and complex decisions. Mental Capacity Assessments must be time and decision specific and followed by best interest decisions.

Whilst one of these people had been deemed to lack capacity to provide consent to care and treatment this had not prompted a review of the consent to care and treatment form that had been signed by a relative in April 2015 or the consent to use specialist equipment form that had been signed by a relative in September

2014. The manager was not able to demonstrate this person had the appropriate LPOA to give this consent.

For two people mental capacity assessments had been commenced even though preadmission assessments recorded no cognitive impairment. The mental capacity assessments stated that the person did not have impairment and nothing further was recorded. However the MCA 2005 states that a person must be assumed to have capacity unless there is reason to doubt this, an assessment would not be needed. This demonstrated that staff may not fully understand the MCA 2005.

The failure to seek consent from appropriate persons and apply the Mental Capacity Act 2005 effectively and in full was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application procedures for this in care homes and hospitals 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.

Deprivation of Liberty Safeguard (DoLS) applications had been made and copies of these were held in people's care records. No conditions were attached with these and the manager knew their role and responsibility in relation to DoLS. We were concerned that one member of staff told us if a person with capacity to make the decision wanted to go out, they would not allow them to go out alone.

The allocation of staff on shift did not always ensure appropriately experienced, skilled and trained staff were available. For example, on the first day of our inspection the senior carer had been in post for one day. They had not received an induction and although the manager told us they had previously worked on the bank team, they also said they had not worked at the home since 2014. They were supported by a member of care staff who had worked at the home for four weeks and had no records to show they had received an induction or had any training.

Eight of 37 staff had not received training in safeguarding. Four of the six staff who worked the morning shift of the 4 October 2016 had not had this training. Four of the seven staff who worked the morning of the 5 October 2016 had not had this training. One of these staff told us they thought safeguarding related to fire and a second told us this was about following policies and procedures, "keeping them safe". They said they would inform the next of kin straight away if there was a safeguarding concern.

The manager told us that ideally they would complete supervisions with all staff every two months. Their line manager told us that realistically this has been happening about every three to four months. The manager had a supervision matrix and whilst this showed that they planned to hold six supervisions a year, dates or months for these were not planned. This matrix showed that 23 of 37 staff had received supervision this year and recorded the others as either being away from work or new starters. However, this showed that seven staff had had their last supervision meeting over 4 months ago. Of the nine staff files we looked at one had been in post about 5 months and had not had supervision since starting employment. Staff confirmed they had started to receive supervisions and that they felt supported by the manager. they said they would not wait for a supervision meeting if they needed to discuss any element of their work with the new manager.

The failure to ensure staff were appropriately supported through inductions, supervision and effective training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The manager had only been in the role of manager for one week. Prior to this they had been the deputy manager. They told us they received support to understand the change in their role and was enrolled to undertake a management level vocational qualification in health and social care. The manager told us that staff new to care would be required to complete the care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. They told us they had not recruited anyone new to care however we later spoke to a staff member who confirmed they had never worked in care before. We discussed this with the manager who told us they had registered this person to complete this certificate. The manager also told us that staff were encouraged to complete a vocational qualification in health and social care after they had worked at the home for six months.

The training matrix showed that training was available in a number of subject areas including moving and handling, safeguarding, mental capacity and deprivation of liberty safeguards, dementia and challenging behaviour. In addition courses had been delivered regarding tissue viability, care planning and diabetes.

At our inspection in February 2016 we found the registered person had not ensured care was planned for and delivered to meet people's needs. Accessing external professionals did not occur promptly for people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach informed the imposed condition on the provider's registration.

An improvement had been made at this inspection and there was no longer a breach of this regulation. Where people had lost weight, action had been taken to address this. Staff had consulted with GP's and dieticians. People's food was being fortified and their weight monitored more frequently. People spoke highly of the food and said they were given plenty of choice. They told us and we observed that if they didn't want what was on the menu they could have something different. All food was freshly prepared. Staff described how they supported people with nutrition and hydration needs including, monitoring their food and fluid intake if there was a concern and monitoring their weight. They described how they fortified foods and drinks if people needed this and would liaise with the dietician if required. Kitchen staff held information about the type of diet people needed, although we noted one person was given the wrong consistency of meal on the second day of our inspection. All except one person's care plans we looked at identified the consistency of diet that was needed. However the manager told us about this one person whom they said sometimes had a normal diet and other times had a soft diet, depending on how tired they were. One member of staff said they thought the person was having a soft diet and a second told us they received a normal diet. This person's care plan lacked clarity about the consistency of diet this person required leaving this open to staff personal interpretation.

Staff were attentive to people's needs and supported people when it was required without hurrying them or reducing their independence. However, due to the staffing levels this did mean that people had to wait for their meals. For example, in the afternoon four care staff were available to support 10 people to eat their meals. Whilst a nurse was also available, we observed they were carrying out the medicines round at this time.

Records showed health and social care professionals visited the service as and when required and that requests for their support were taking place much quicker than at our previous inspection. Care records held feedback from GP's, speech and language therapists, social workers and occupational therapists. Staff identified people's needs and involved health and social care professionals appropriately.

Good

Is the service caring?

Our findings

People and their relatives felt staff were kind and caring. They felt staff respected the choices they made and supported them to maintain their privacy and dignity.

At our inspection in February 2016 we found people were not always treated in a dignified and respectful manner. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a requirement notice and the provider sent us an action plan stating they would be compliant with the regulation by 29 April 2016.

At this inspection we saw improvements had been made and there was no longer a breach of this regulation. People and their relatives spoke highly of staff who they described as kind and caring. Staff often referred to people using terms of endearment such as darling, or sweetheart. People confirmed they did not mind this. When speaking to people staff got down to the same level as people and maintained eye contact. Staff explained what they were doing when they supported people and gave them time to decide if they wanted staff involvement or support. Staff spoke clearly and repeated things so people understood what was being said to them.

Staff showed they had a caring attitude towards people and recognised when they needed support. All except one observation showed that staff recognised if people were distressed and provided kind, and caring reassurances. We reported the one observation to management who took action to address this. One person was informed of the loss of a loved one on the second day of our visit. Staff discreetly shared this information between them and reminded each other this person may need extra support. When talking to this person they showed empathy and understanding.

Staff ensured do not disturb signs were used during personal care to support people to maintain their privacy and dignity. Discussion with staff showed they had a good knowledge of how to maintain this and why it was important. Staff knocked on people's bedroom doors and asked permission to enter.

People were encouraged to make choices during the day, including the clothes and jewellery they chose to wear, where they spent their time and choices in respect of food and participation in activities.

Resident meetings took place monthly and people could discuss any issues they chose to. These were run by the activity staff who told us the notes were given to management to act on. The manager told us their plan would be to review each of these meetings and develop action plans following this. They had not had the opportunity to do this at the time of our inspection as they had only been the manager for one week. People and their relatives felt able to contribute and make suggestions.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy living at the home and felt supported by staff who understood their needs. One told us how they were able to personalise their room. People told us they had no complaints. They said they knew how to raise a complaint and who to talk to they should have any in the future.

At our last inspection in February 2016 we found the registered person had failed to ensure person centred planning and delivering of care based on people's identified needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach informed the imposed condition on the provider's registration.

At this inspection we saw improvements had been made and there was no longer a breach of this regulation, although further work was required to ensure records were accurate, up to date and reflected people's individual needs.

Staff had a good understanding of people's needs, preferences, likes and dislikes. People and their relatives told us how they were consulted about their care and that staff asked how they wanted to be supported. Care plans included people's preferences and wishes. For example for one person their care plans detailed how they liked to watch TV most of the day. They detailed how they did not like to get dressed and preferred to stay in their night wear.

For a second person we saw their care plans detailed how they loved singing and listening to music. This person spent a significant amount of time in their room and when we visited them their music was playing.

Some care plans showed how staff responded to a change of need, for example one person's medication care plan recorded how they were not always swallowing their tablets so liquid pain relief had been prescribed. However, other care plans were not always reflective of current needs. For example this person's emergency evacuation plan referred to the needs and abilities of another person. A second person dietary care plan lacked clarity about the consistency of diet this person required leaving this open to staff personal interpretation. For a third person a skin care plan stated their skin was intact when they had a wound care plan which identified they had a wound on their leg.

Handovers took place at every shift which staff told us they found useful as this helped them to keep up to date with people's changing needs. A handover record was provided to each staff member which contained some basic information they needed about the person's diagnosis and needs.

An activity staff member was employed to work in the home. This person knew people well and understood their likes and history. They told us how they supported people in groups and also on a one to one basis. For example, they told us how they spent time with one person reading a magazine. External entertainers visited the home and on the first day of our inspection we saw that people engaged with and appeared to enjoy a musician visiting. No activities had been planned for the second day although a hairdresser visited and some people chose to have their hair done. One said "I feel like Lady Muck", after spending time with the

hairdresser. We saw records which confirmed that the activity staff member used the resident meetings to get feedback from people and ideas about the types of things they wanted to do. For example, at the most recent meeting on 3 October 2016 one person had said they wanted an exercise class using a ball and the activity staff member told us they would explore this.

At our last inspection in February 2016 we found the registered person had failed to ensure complaints were acted upon promptly. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement notice was issued and we received an action plan which said that the provider would ensure an effective complaints system was in place. They said they would be compliant with this regulation by 29 April 2016.

At this inspection this had improved and there was no longer a breach of this regulation. Records of complaints made to the home were held in a central file with a log of when they were received and dealt with. We saw action had been taken to address these at the time of the complaint and the person who made the complaint had confirmed they were satisfied with the outcome. However, we did note that one issue that had been raised as a complaint and recorded the action taken to address the concern was not done during our inspection. In this case, a concern was raised about a person's access to their call alarm. However, we noted that their call alarm was not within easy reach and they were not always wearing a pendant alarm. The manager said that this person did not like to have the pendant call bell when they were laid down however; this was not reflected in the care plans. Staff were able to describe to us how they would support people to raise a complaint if they had any.

Inadequate

Is the service well-led?

Our findings

Feedback from an external health professional was that they felt clinical leadership was lacking. A registered manager was not in post however, the deputy manager had been promoted to manager and had begun the application process with the Commission. They had been working as the manager for one week at the time of our inspection. They were not a nurse. However, a new deputy manager and clinical lead had been appointed. At the time of our inspection the deputy manager had only been in post for three days. They were able to tell us how they had identified some improvements were needed in the home that they would hope to drive forward, including ensuring that registered nurses took a lead role in managing the shifts and that care plans were further improved on in terms of detail and accuracy. They said they had identified a need to improve on wound care plans especially. The manager and their line manager told us how they felt improvements to the service had been made especially in relation to the care plans and risk assessments.

At the last inspection we found that systems in place to drive improvement were not effective. Records were not accurate and always available. Feedback from others was not always used to make changes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach informed the imposed condition on the provider's registration. This condition required the provider to undertake weekly audits of people's needs, care plans, risk assessments and medicines management and send the Commission a monthly report.

We imposed the condition to support and ensure the provider assessed aspects of the service which could pose a risk to people and take appropriate action. However, we were not confident in the systems the provider used to assess these areas as the information the Commission had been provided with as a result of this condition, we found to be inaccurate and not reflective of our findings.

The monthly report we received in respect to the condition imposed covered the period of September 2016. This identified no concerns or actions required as a result of weekly audits of medicines. We looked at the individual audits and found these were not effective in identifying errors and taking action to address these. For example we identified that three people's medicines were in the blister pack despite being signed as being given. The individual audits had not identified this. They did not identify the gaps in the recording of medicines administration. The manager was unaware of these errors. An effective audit would have identified these concerns and planned action to make improvements.

The monthly report we received in respect to the condition imposed covered the period of September 2016 identified no concerns or actions as a result of the weekly care plans and risk assessment audits. We reviewed the individual audits and found these were ineffective in identifying areas for improvement. For example, one person's emergency evacuation plan referred to another person and their abilities and needs. The care plans audits had not identified this and the tool used did not prompt staff to look at this. In addition this person displayed behaviours which could pose a risk to them and others but the care plan audits had not identified that no risk assessment or care plan had been developed. For a second person it did not identify the lack of a choking risk assessment and lack of records regarding external professional involvement. For a third person, their medicines were being given covertly. We saw that discussions had

been held with the GP and family member. A capacity assessment had been completed regarding consenting to the support within their medicines care plan. However the capacity assessment did not specifically mention covert administration and the best interests discussion dated before the capacity assessment, was not clearly recorded as it did not contain the views of others consulted with. The audit did not identify the concerns with these but the tool used did not prompt staff to look at aspects of consent and capacity. An effective audit would have identified these concerns and planned action to make improvements.

The provider's "Monthly Home Audit" had only been carried out twice since our last inspection in February 2016. This had been completed in April 2016 and the last one on 5 and 6 September 2016. This audit tool assessed all areas of the service and identified if actions were required, although where actions were identified timescales for the completion of these were not set. The audit had been effective in some areas but this was not consistent. For example, we saw this identified the need to ensure daily records were completed at every shift and staff were not interrupted during medicines rounds. We observed staff were not interrupted during medicines rounds and daily records appeared complete.

However, elements of this audit were not fully effective. For example, this recorded that no actions were required to ensure care plans reflected person centred care. However it was not recorded whose records were viewed. Whilst we saw improvements to some care plans this was not consistent. For example one person's dietary care plan lacked clarity about the consistency of their diet. Another person's care plan lacked guidance about the management of behaviours that placed them and others at risk. A fully effective audit would be clear about whose records were reviewed and would identify concerns and any areas that needed improvement.

This audit also reviewed the recruitment records of staff although it did not specify whose records were reviewed. This stated that one member of staff did not have any references and that the audit recorded that this person was not to return to work until these were received. We found that subsequent to this audit a member of staff was recorded on the rota as working on shift despite their records showing no references. Another member of staff had been employed since this audit had been completed and no references had been sought meaning that the audit was not effective in ensuring learning took place and improvements were made.

An external audit of the service had been carried out in June 2016 and identified improvements that could be made. An action plan had been implemented following this which stated "all actions to be completed within 1 month or immediately where possible". Whilst the action plan addressed some of the issues, this was inconsistent. We saw that the external audit identified the need to improve on recruitment processes. Although this was recorded on the action plan, the action taken section was blank and it had not been signed off as being completed. We identified concerns regarding the recruitment processes undertaken in the home as this did not demonstrate that the provider's policy was followed and safe recruitment practices were in place. In addition the external audit recommended a review of staff deployment and numbers would be helpful. The action recorded for this was for "move higher need S.U's to areas of high staff presence". However, there was no evidence that a review of staffing levels and how they were deployed was undertaken. We identified concerns regarding staffing levels especially in the afternoon/evening and around meal times.

The audit identified the need to update and personalise some older care plans. This was recorded as an action but no action taken had been recorded and it had not been signed off as being completed. We identified concerns with some records including one person's pain care plan dated 2014 which referred to an injury they received in 2014 and that this still causes them pain. There was nothing recorded to indicate

that this injury was still causing pain. A second person's nutrition care plan provided information about the consistency of fluids for them but not of their diet and staff gave differing opinions. However, other areas of the audit recommendations had been completed including a review of accident and incident recording and monitoring.

Whilst this audit had identified concerns and been used to develop an action plan, the action plan had not been fully carried out and used to ensure the improvements needed were undertaken.

Systems in place to drive improvement were not effective and records were not always accurate. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst we continued to find concerns with the providers compliance with Regulation 17 the condition imposed by the Commission requires them to take weekly action to make the improvements needed and ensure this regulation is met. The Commission considered this condition remained appropriate.

Other systems used to assess quality and drive improvement were also in place and appeared more effective. Feedback had been sought from staff and people in the form of surveys. In August 2016 responses had only been received from three staff and three people who lived in the home. An action plan had been developed following this. Feedback from all three people included the need to increase the staffing levels as staff did not always respond promptly. The action plan recorded that staff recruitment was ongoing and stated that "staff numbers have increased at night and in the morning, staff numbers in the afternoon will also be increased."

Staff feedback included feeling undervalued and the action plan recorded how a BBQ had been arranged to help staff feel valued and staff incentives had been introduced such as employee of the month.

Staff told us they felt supported and valued by the new manager. They described the manager as friendly and helpful. They said they were confident that she would support them if they needed it and they felt if she didn't know she would seek the support from another manager to be able to help them. Staff said they felt they were able to make suggestions and these were listened to. They told us about the introduction of a white board to ensure all staff knew what times people required specific support needs. They said this was working well in the home. Staff meetings with all staff had not taken place since June 2016 and the last nurses meeting was in July 2016. The manager said they recognised these needed to be more frequent but advised that they operated an open-door policy so staff could approach them at any time. Staff confirmed this.

At the last inspection we found that the registered persons had failed to notify the CQC of a range of matters and significant incidents. This was a breach of Regulation 14 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. A requirement notice was issued and we received an action plan which said that the provider would ensure all incidents and events that required reporting would be reported. They said they would be compliant with this regulation by 27 May 2016.

At this inspection this had improved, there was no longer a breach of the Registration Regulations and we did not identify any incidents that required reporting to the Commission that we had not been notified of.

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 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to seek consent from appropriate persons and apply the mental capacity act 2005 effectively. Regulation 11(1)(2)(3)

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 The registered person had failed to ensure safer recruitment processes of all staff. Regulation 19(2)(a)(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 person had failed to ensure suitable numbers of appropriately supported supervised and trained staff at all times. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not safe. Regulation 12(2)(g)

The enforcement action we took:

We previously imposed a condition on the providers registration requiring them to take weekly action to make the improvements needed and ensure this regulation is met. The Commission considered this condition remained appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to drive improvement were not effective and records were not always accurate. Regulation 17(1)(2)(a)(c)

The enforcement action we took:

We previously imposed a condition on the providers registration requiring them to take weekly action to make the improvements needed and ensure this regulation is met. The Commission considered this condition remained appropriate.