Premiere Care (Southern) Limited

The Elizabeth Anne Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 10 April 2015, was unannounced and was carried out by one inspector and a specialist advisor.

The Elizabeth Anne Nursing Home is a privately owned service providing nursing care and support for up to 27 older people and people who may have mental health needs. The needs of the people varied greatly. Some people were very frail and immobile and other people were independent and able to go out on their own. Some people also had behaviours that challenge and communication needs. There is a registered nurse on duty at the service every day and night. There were 14 people living at the service at the time of the inspection. Each person had their own bedroom which contained their own personal belongings and possessions that were important to them.

Summary of findings

We last inspected The Elizabeth Anne Nursing Home in October 2014. At that inspection we found the provider had not taken action to meet outstanding breaches of the regulations identified at previous inspections in November 2013, July 2014 and October 2014. These were in relation to the care and welfare of people who use the service. We found at the October 2014 inspection the provider was in breach of the regulation that related to consent to care and treatment. The provider was meeting this regulation at this inspection but did not meet the regulation relating to people's care, welfare and support. We are currently in the process of taking enforcement action against the provider.

In October 2013 we issued a Notice of Decision preventing the registered provider from admitting any more people to The Elizabeth Anne Nursing Home. This notice was still in force at the time of this inspection.

At the time of the inspection the service did not have a registered manager in post. The service had not had a registered manager since 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

Since our last inspection the Nominated Individual had changed. A Nominated Individual is the person who must be employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity.

Safeguarding procedures were in place to keep people safe from harm. On one occasion these procedures had not been followed by the manager as they were unaware of the full facts of an incident that had occurred. The local authority safeguarding team had not been informed of the incident which they should have been as part of the provider's safeguarding procedures. People told us and indicated that they felt safe at the service; and if they had any concerns, they were confident these would be addressed quickly by the manager. The staff had been trained to understand their responsibility to recognise and report safeguarding concerns and to use the whistle blowing procedures.

Everyone had a care plan which was personal to them and that they or their representative had been involved in writing. The contents, information and quality of care plans varied. Some care plans were clear and precise, while other care plans did not record all the information needed to make sure staff had guidance and information to care and support people in the way that suited them best and kept them safe. Some people were at risk because of their medical conditions and their complex needs. Potential risks to people were not always identified. There was either no information or guidance for staff on how to reduce the risk and keep people safe and meet their individual needs or the guidance was unclear and inaccurate. This left people at risk of receiving unsafe or inappropriate care and treatment.

The staff did monitor people's healthcare needs but they did not consistently act on issues that were identified and any changes in people's health conditions. Staff, including a nurse,were inconsistent and unsure, when we asked, about how they would meet some people's health needs. This left people at risk of their health conditions deteriorating further as they were not always receiving the consistent care, support and treatment they needed to make sure their health was promoted.

People with behaviours that challenge were not given consistent care and support as there was no individual guidance available on how to manage the behaviours.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager showed that they understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. People had been assessed as lacking mental capacity to make complex decisions about their care and welfare. Individual DoLS applications had been made for people living at the service but no decisions had been made yet. Applications were still being processed by the DoLS office. Urgent DoLS restrictions had been granted. The staff had received training in DoLS and MCA.

Summary of findings

Staff were caring and respected people's privacy and dignity. People were involved in activities which they enjoyed. Staff were familiar with people's likes and dislikes, such as if they liked to be in company or on their own and what food they preferred.

People said and indicated that they enjoyed their meals. People were offered and received a balanced and healthy diet. They had a choice about what food and drinks they wanted. If people were not eating enough they were seen by dieticians or their doctor and supplement nutrition was provided. People received their medicines safely and when they needed them and they were monitored for any side effects. If people were unwell or had deteriorating needs the staff contacted their doctors or specialist services.

There were positive and caring interactions between the care staff and people. When people could not communicate verbally staff anticipated or interpreted what they wanted and responded quickly. Staff were respectful and kind when they were supporting people. People appeared comfortable and at ease with the staff. A system of recruitment was in place to ensure that the staff employed to support people were fit to do so. Staff had the appropriate safety checks prior to working with people to ensure they were suitable. The staff had received basic training but were not all competent in the skills needed to meet some people's health needs. There were sufficient numbers of staff on duty throughout the day and night to make sure people were safe and received the care and support that they needed.

Staff had support from the manager to help them care safely and effectively for people. Staff had received regular one to one meetings with a senior member of staff. Staff had completed induction training when they first started to work at the service and had gone on to complete other basic training provided by the company. There were regular staff meetings. Staff said they could go to the manager at any time and felt they would be listened to. They said the new manager was very supportive.

The complaints procedure was available in a format that was accessible to people. Feedback from people, their relatives and healthcare professionals was encouraged and acted on wherever possible. Staff told us that they felt the service was well led and that the management team were supportive and approachable. Staff said the there was a culture of openness at service which allowed them to suggest new ideas which were often acted on. Quality assurance systems were in place. Audits and health and safety checks were carried out but they were not always effective in that not all of the shortfalls had been picked up and or acted on.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and cancelled the provider's registration for this service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People had not been fully protected from abuse and harm as safeguarding policies and procedures had not been consistently followed. Staff knew what abuse was and how to report any suspicions. People with behaviours that challenge were not given consistent care and support as there was no individual guidance available on how to manage the behaviours.

Not all risks to people were fully assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible.

People's medicines were managed safely.

There was enough staff on duty to make sure people received the care and support they needed. Recruitment procedures ensured new members of staff received appropriate checks before they started work.

Is the service effective?

Requires improvement

The service was not effective.

Staff lacked understanding about people's health care needs which had led to people receiving unsafe care. Staff, including a nurse, were not sure about how to support people's health needs. There was a lack of recorded guidance about how to support people's health needs.

The registered manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and people's mental capacity to consent to care or treatment was assessed and recorded.

Staff had regular one to one meetings or appraisals with the registered manager or with a senior member of staff. Staff had an induction when they first started to work at the service. There was an on-going training programme for staff covering basic training.

People had enough to eat and drink and had a choice of meals.

Is the service caring?

Requires improvement

The service was caring.

Staff knew about people's backgrounds but lacked understanding about some people's health needs.

Staff communicated with people in a caring, dignified and compassionate way. If people were unable to communicate using speech staff made gestures and signs that they could understand.

People and their relatives were able to discuss any concerns regarding their care and support. People's privacy was supported and respected.

Summary of findings

The staff involved people in making decisions about their care and support. People, when they were able, were involved in reviews of the care being given. If people were unable to do this the staff sought the support of advocates to speak on behalf of people.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care and support was not always given in line with their individual care plans and to meet their changing needs.

People were involved in talking about their needs, choices and preferences and how they would be met.

People were able to raise any concerns or complaints with the staff and manager, who listened and took the appropriate action.

Is the service well-led?

Inadequate

The service was not consistently well – led.

The was no registered manager in post to lead and direct the service to make sure people were receiving the care and support that they needed to keep them safe and healthy. There had been no registered manager since 2012.

Records were not suitably detailed and were not accurate or clear.

There were systems in place to monitor the services progress using audits and questionnaires. These audits had identified the shortfalls but action had not been taken to address the shortfalls.

The Elizabeth Anne 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 10 April 2015 and was unannounced. The inspection was carried out by one inspector and a specialist advisor. The specialist advisor was someone who had clinical experience and knowledge of working with people who were living with dementia.

The provider had previously completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when significant events happen, like a death or a serious injury.

We spoke with or observed the support received by the 14 people who lived at the service and spent time with five of them. As some people could not talk to us we used different forms of communication to find out what they thought about the service. We looked at how people were supported throughout the day with their daily routines and activities. We observed staff carrying out their duties. These included supporting people with their personal care, encouraging people to be involved and engaging people in activities.

We spoke with seven members of staff, which included a registered nurse, a team leader and the cook. We also spoke with the manager, the area manager and the provider of the service. We looked around the communal areas of the service and some people gave us permission to look at their bedrooms.

We assessed if people's care needs were being met by reviewing their care records and speaking to the people concerned. These included five people's care plans and risk assessments. We looked at a range of other records which included four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

We last inspected The Elizabeth Anne Nursing Home in October 2014. At this inspection we found that people's consent to care and treatment was not obtained according to the law and people did not always experience care, treatment and support that met their needs and protected their rights. We are currently in the process of taking enforcement action against the provider.

Requires improvement

Is the service safe?

Our findings

The provider had policies and procedures to make sure that any concerns about people's safety were reported. There was one incident recorded which had involved people verbally confronting each other and this was a potentially abusive situation. Staff had not followed the procedures. Staff had not reported the incident to the local authority safeguarding team who would have discussed the issue and then made a decision on how to proceed. The staff had not reported the full details of the incident to the manager and the manager said that she was not aware that it involved two of the people living at the service. This was discovered at the inspection, when the inspector read the incident report. There was a risk that staff may not understand fully what constituted abuse and did not make the manager aware of incidents that happened at the service that needed to be reported to the local authority safeguarding team.

People were not fully protected from abuse as policies and procedures were had not been followed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and indicated that they felt safe. People looked comfortable with other people and staff. People said and indicated that if they were not happy with something they would report it to the manager who would listen to them and take action to protect them. Staff knew people and were able to recognise signs through their behaviours and body language if people were upset or unhappy. Staff explained how they would recognise and report abuse within the organisation. They had received training on keeping people safe. They told us they were confident that any concerns they raised would be taken seriously and fully investigated to ensure people were protected.

Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly. One staff member said, "If I ever saw anyone harming one of our residents I would report it immediately. The manager is very open and has taken firm action in the past. I would trust them to sort it out."

The manager had recently raised two safeguarding alerts with the local safeguarding authority which had resulted in action being taken to ensure people's safety. Staff were suspended from duty until the alert had been investigated and an outcome reached.

Risks to people had been identified and assessed but guidelines on what to do if an incident happened were not available. Some people were identified at being at risk from choking, falling over or exhibiting behaviours that challenged. There was information and guidance available for each person to tell staff how to prevent this from happening but there was no instruction to say what to do for each individual if they did start to choke, fall over or behave in a challenging way. People's needs were diverse. Some people were in wheelchairs, some people were in bed, so staff would have to respond very differently to each individual. People were at risk of of not receiving the individual care and support they needed to keep them as safe as possible.

People with behaviours that challenge were not given consistent care and support as there was no individual guidance available on how to manage the behaviours. There was a management plan in place to support staff working using positive interventions to aid the management of a person's anger. However, further information regarding what staff should do if physical aggression occurred was not clearly documented. Staff told us how they dealt with a person who had behaviours that challenged. Some staff said that they never had any problems and that it all depended on how they approached the person and how they spoke to them. Other staff told us, they did not know how to respond and 'tried to keep out of the way'. Staff were unable to tell us how they would safely care and support a person who had behaviour that challenged to protect them and other people.

People were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines when they needed them. The trained nurse on duty gave people their medicines. They went to each person and individually asked them if they wanted to take their medicines. They asked people if they were in any pain and if they wanted any medicine to help alleviate the pain. There were policies and procedures

Requires improvement

Is the service safe?

in place to make sure that people received their medicines safely and on time. Medicines were administered from a trolley in which they were stored securely. When not in use the trolley was stored securely in a locked cupboard. The stock cupboards and medicines trolleys were clean and tidy, and were not overstocked. Bottles and packets of medicines were routinely dated on opening. Staff were aware that these items had a shorter shelf life than other medicines, and this enabled them to check when these were going out of date. Some items needed storage in a medicines fridge, the fridge and room temperatures were checked daily to ensure medicines were stored at the correct temperatures. Administration records showed that medicines were administered as instructed by the person's doctor.

Some people were given medicines on a 'when required' basis if they presented with a behaviour that was considered challenging or if they were experiencing any pain. There was a written criteria for each person who may need 'when required' medicines.

There were enough staff on duty to meet people's needs. People, who could, said that the staff were always available when they needed them. Staff responded quickly to people's needs and people were not kept waiting if they needed something. If a call bell rang in someone's room the staff went immediately to answer it. Staff told us there was enough staff available throughout the day and night to make sure people received the care and support that they needed. The duty rota showed that there were consistent numbers of staff working at the service. There were arrangements in place to make sure there was extra staff available in an emergency and to cover for any unexpected shortfalls like staff sickness. When there was not enough staff available the manager used agency staff. On the day of the inspection the staffing levels matched the number of staff on the duty rota and there were enough staff available to meet people's individual needs. Staff told us, "We have an excellent core team, but have to use too many agency staff at the moment. If I could change one thing it would be to have more regular staff. I love coming to work and we all help each other out".

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. Staff files showed that the relevant safety checks had been completed before they started work. The manager interviewed prospective staff and kept a record of how the person performed at the interview. Records of interviews showed that the interview was fair and thorough. Staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work.

There were systems in place to review any accidents and incidents that happened at the service. These were analysed and improvements were made if any trends or patterns were identified. This helped reduce the risk of further accidents and incidents.

The staff carried out or arranged regular health and safety checks of the environment and equipment. These included engaging contractors to ensure that electrical and gas appliances at the service were safe. Regular checks were carried out on the fire alarms and other fire equipment to make sure it was in working order. People had a personal emergency evacuation plan (PEEP) and staff and people were regularly involved in fire drills. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of a fire.

Requires improvement

Is the service effective?

Our findings

People's healthcare needs were monitored but there was an inconsistent approach by staff when supporting people's health needs and when health needs deteriorated. When people had a medical condition like epilepsy they had a care plan in place but this did not give clear and consistent guidance on what to do if a seizure occurred. One epileptic seizure plan stated to give a medicine called Midazolam (This is a medicine that helps stop epileptic seizures). The care plan did not state at what point this medicine was to be given or how much. Staff were not sure when to give it. The care plan did not state the length of time staff should monitor the seizure for before taking further action, like giving the medicine or calling an ambulance. Staff were not sure about how long they should allow a seizure to continue before calling for help or taking action. The nurse told us that they would leave the person in a seizure for 100 minutes for calling for help. 100 minutes is a very excessive length of time to leave a person in a seizure and could result in serious harm to the person.

People appeared healthy and well nourished but some people were at risk of losing weight. When this was the case staff weighed people to monitor their weight. Some people were not always weighed regularly enough for staff to have clear information about any weight loss. Other people were at risk of choking. There was information to tell staff what to do to try and prevent people from choking, like thickening their drinks, giving them a pureed diet and making sure they ate slowly. There was no guidance on what to do if a person did start to choke. When a person was at risk of choking three staff told us three different actions they would take if a person started to choke. Their responses were inconsistent and some actions they said they would take posed a greater risk to people.

When people were on special diets the staff and chef made sure that these were available. Staff were discreet and sensitive when they were supporting people with their meal. Drinks and snacks were available to people throughout the day and staff encouraged people to drink to reduce the risk of dehydration. People who had specific health needs like diabetes, that was controlled by diet, were supported by staff to manage their diets to make sure they were as healthy as possible. Mealtimes were a sociable and enjoyable occasions. People appeared to enjoy their meals.

When people had catheters or had conditions like diabetes that was insulin controlled, there was no clear guidance in place to explain how to support and treat people safely and effectively to make sure they received the care that they needed to promote and maintain their health.

People were at risk of not having their healthcare needs met safely as staff were unsure and inconsistent in the actions they would take to meet people's needs. Staff did not have the necessary competencies and skills to deal with people's health needs effectively. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff looked after them well and the staff knew what to do to make sure they got everything that they needed. People said they thought they received good, effective care. There was a training programme in place covering basic training subjects.

The staff team knew people and knew how they liked to receive their care and support. Staff were attentive and anticipated the needs of people when they could not say what they wanted or needed. People and staff got on well together. Staff were able to tell us about how they cared for each person to ensure they received effective individual care and support. They were able to explain what they would do if people became upset or restless.

Staff told us that they had an induction when they began working at the service. Staff initially shadowed experienced colleagues to get to know people and their individual routines. Staff were supported during their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs. Staff were able to tell us what training courses they had completed. They said that the training was good and supported them to do their job in the best way. The manager kept a training record which showed when training had been undertaken and when 'refresher training' was due.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act is a law that protects and supports people who do not have the ability to make decisions for themselves. DoLS protects the rights of people by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The

Is the service effective?

manager was aware of the recent Supreme Court Judgement which made it clear that if a person lacked capacity to consent to arrangements for their care and were subject to continuous supervision and control and

were not free to leave the service, they were likely to be deprived of their liberty. Staff said that they had received training regarding these topics. Staff said that they felt MCA and DoLS was a difficult issue to understand. Staff were aware that there was an increasing focus at the service on mental capacity issues.

Some staff were able to give good examples of capacity issues such as "If I am helping someone (without capacity) with their personal care we need to know if we are helping them as they would want us to."

Some staff had difficulty identifying practical examples of depriving liberty, but one staff member said, "We have key pads on the doors to protect most of our residents, but some people can go out when they want, but have to ask me to let them out."

The manager and staff were aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest. People had received advocacy support when needed to make more complex decisions, Independent Mental Capacity Advocates, (IMCA - an individual who supports a person so that their views are heard and their rights are upheld) had been involved in supporting people to make decisions in their best interests. The registered manager had considered people's mental capacity to make day to day decisions and there was information about this in their care plans. There were mental capacity assessments in place to determine whether people had capacity or not to make decisions. Mental Capacity Act assessments had been completed and reviewed in relation to more complex tasks and decisions such as personal care, the use of bed rails and the use of covert medication.

When people's behaviour changed and there were changes made to their medicines, these decisions were made by the right clinical specialists with input from the staff. When people lacked capacity to give consent to these changes there was a mental capacity assessment available and best interest decision making was recorded.

Best interests meetings and DoLS authorisations were in place to address the key pad access to the exits of the service. Urgent authorisations had been initially put in place by the manager. There was evidence that full authorisations were granted within the 7 day timescale following liaison with key professionals for each person.

All staff said that the use of any form of physical restraint was not allowed and not necessary. One new member of the care team said, "It should never be necessary. One of our residents can become physically aggressive, but I tell them I cannot help them when they try to hit me and say I will come back when they calm down or use diversion techniques."

Staff told us that they had regular one to one meetings with the manager or senior staff when they could discuss their training needs and any concerns or problems. Part of the process included staff being observed carrying out their daily duties and having their competence assessed. We were concerned about the effectiveness of these competency checks as not all staff we spoke with were competent about how to meet some people's health needs. Staff said that they would go to their manager at any time to discuss concerns or ask questions and that there was an 'open door' attitude. The manager had an annual appraisal system to give staff feedback on their performance. Some staff had had their appraisals and others were scheduled to take place. This was an opportunity for the manager and staff to discuss any identified development and training needs and set personal objectives. When training needs were identified staff were supported to access the necessary training. If staff were not achieving their personal objectives they were supported by the manager and senior staff to look at different ways to achieve them.

People were encouraged and supported to eat a healthy diet. People told us that they had a choice of meals every day and if they did not like the choices they could have something else. People were able to eat in lounges, dining areas or bedrooms according to their choice and their state of health. At lunch time people sat where they wanted to in the dining room. Some people preferred to eat separately from others and this was respected by staff and other

Requires improvement

Is the service effective?

people. People said and indicated that they liked the meals and the food. Some people were able to tell us what their favourite foods were and said that they had these often. The staff and the chef knew what people liked and disliked.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. When people had difficulties swallowing they were referred to and seen by the speech and language therapist so they could be assessed for the best way to give them food and drink while reducing the risks of choking. If people's mental health deteriorated they were seen by the local older people's mental health team or the psychiatrist. If a person was unwell their doctor was contacted. People were supported to attend appointments with doctors, nurses and other specialists when they needed to see them.

Requires improvement

Is the service caring?

Our findings

People said and indicated that they thought the staff were caring. People were relaxed with the staff. They talked together and appeared to enjoy each other's company. Staff comforted people when they were upset or restless. Staff sat with people and stroked their hands or sang them their favourite song. People smiled and sometimes joined in.

Staff said, "I care very much for everyone who lives here. We are like a family. I spend a lot of my life here so you can't help getting attached to people." and "We all go the extra mile because we care."

Staff were aware of people's life histories and backgrounds but did not all fully understand how to support some people's specific, and sometimes complex, health needs.

Some people were not able to express themselves using speech. Staff were able to interpret and understand their wishes and needs and supported them in the way they wanted. Staff supported people in a friendly way, had a friendly approach and showed consideration towards people. Staff were kind, compassionate and sensitive to people's needs.

Staff asked people what they wanted to do during the day and supported people to make arrangements. The staff team were polite while supporting people and while talking with each other. People were involved in what was going on and were aware of what was being said and were involved in conversations between staff. Staff gave people the time to say what they wanted to say. They listened to people's views and took action to support their wishes. People were supported to be as independent as possible and were always offered choices even if an individual was unable to express a clear opinion. One person with limited mobility was supported by two care staff to walk to another room. One staff member explained what they were about to do and offered simple instructions whilst the other staff member provided support using a hand support sling. The person was allowed time and was encouraged to pause when their posture changed. Staff said they tried to only use wheelchairs when necessary as they wanted to promote people's independence and maintain their skills.

People, when they were able, were involved in planning their own care and deciding what they wanted to do. If people had family then their views and opinions were asked for. Some people did not have relatives who could support them. In these cases the people had access and visits from advocates to make sure they were supported to have a 'voice' about the care and support they wanted and needed. The advocate was there to represent people's interests, which they did by supporting people to speak, or by speaking on people's behalf.

People's preferences about what care and support they needed with their personal hygiene routine were detailed. Staff understood, respected and promoted people's privacy and dignity. Staff knocked on people's bedroom doors and waited for signs that they were welcome before entering people's rooms. They announced themselves when they walked in, and explained why they were there. Staff were discreet and sensitive when supporting people with their personal care needs. Personal care was given in the privacy of people's bedrooms or bathrooms. People, if they could, moved freely around the building. They could choose whether to spend time in their room or in communal areas. Staff told us that visitors were welcome at any time.

Requires improvement

Is the service responsive?

Our findings

At the last inspection in October 2014 we asked the registered person to take action to make improvements to protect people from the risk of inappropriate and unsafe care. Following the inspection the registered person sent us an action plan to tell us of the improvements they were going to make. At this inspection the shortfalls were still evident.

People had a wide range of needs. Some people were independent and required minimal support from staff. Other people required support from staff to meet all of their needs including eating and drinking, keeping clean and moving around the service. People, who were able to tell staff what support they required and how they would like this to be done, remained as independent as they could be. Other people who had more complex needs and who required a higher level of care and support were at risk of not getting the care, treatment and support that they needed. This was because the staff were unable to communicate verbally with some people and their care plans and risk assessments were not clear and did not contain the information and guidance about the care and support that they needed.

The care plans had all been reviewed and updated between January 2015 and March 2015. Everyone had a care plan and risk assessments in place. Some of the care plans contained the individual guidance and information staff needed to provide the care, support and treatment people needed in the way that suited them best. Other care plans were not accurate or clear and did not reflect people's current needs, despite being reviewed. This put people at risk of receiving inconsistent and unsafe care and support because staff did not have a clear plan to follow.

A person with diabetes had their diabetic medicines reviewed as their diabetes had become unstable. Staff were required to change the amount of diabetic medicines at certain times as their blood sugar levels were fluctuating. The person's diabetes care plan had not been updated to reflect the changes and at the time of the inspection the person's medicines record was also unclear and not up to date with the changes. The person had recently been given an incorrect amount of insulin. When this was identified by the manager they took appropriate action to deal with the incident.

A person had a catheter in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. The care plan for the catheter did not state clearly what to do if the catheter blocked. It did not give staff the guidance or instruction on when the catheter should be changed and it did not say what size catheter to use. When the catheter had blocked the trained nurse tried three times to insert a new catheter. They used different size catheters. There was no guidance in place to tell staff what to do if they could not insert the catheter. The outcome for the elderly person was that they had to go hospital.

In the care plan for another person the information regarding the recording of weights was inconsistent. This was an issue that had been previously raised by the local adult social services team. The most recent care plan stated that 'due to (the person's) best interests they are not to be weighed.' However, instructions on a different care plan stated that the individual was to be weighed weekly and weight records showed that the person had previously been weighed monthly.

People were at risk of receiving inconsistent and unsafe care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the care plans provided personal background information about people. This included a section called 'This is me'. The activities co-ordinator had invested a lot of time working with families and people to develop life stories and scrap books with old photographs for each person. People enjoyed looking at these and talking about their past, their families and what was important to them. Staff were able to talk about people's life histories and preferences, including a new member of staff who had been at the service for three weeks.

Staff spoke about respecting people's rights and supporting people to maintain their independence and make choices. People were supported to keep occupied and there was a range of activities on offer to reduce the risk of social isolation. The provider employed an activities co-ordinator who planned activities each day. People were supported to do what they wanted. People had choices to do different things like shopping and visiting places. Staff were aware if people chose not to take part in group activities and made sure that they were offered alternative activities. Staff spent one to one time with people doing puzzles and quizzes or chatting. Some people were able to

Requires improvement

Is the service responsive?

go out on their own in the local area and others were taken out with the support of staff. People enjoyed a sing-a-long and the ladies enjoyed pamper sessions. People were supported to go to church and there were visits from people living in the local community. There were opportunities for people to express their views about their own support and care. Staff listened to what people said and acted according to their wishes.

The provider had a policy in place which gave guidance on how the provider handled complaints. There had been no recent complaints. Staff felt confident to pass complaints they received to the manager or senior member of staff. Concerns from people were resolved quickly and informally. When complaints had been made these had been investigated and responded to appropriately. The service had a written complaints process that was written in a way that people could understand. Each person had information about how to complain which was kept in their rooms so that they could access it easily. People told us they would raise any concerns with the manager or staff and felt that they would be listened to.

Inadequate

Is the service well-led?

Our findings

There had been no registered manager at the service since 2012. The provider had not complied with the conditions of their registration because they had failed to appoint a registered manager to manage the service. The provider was aware of their responsibility to do this. When we previously inspected the service we recorded in the summary of the inspection report that there was no registered manager in post. We have previously taken action against the provider for having no registered manager.

The provider failed to have a registered manager in post. They are carrying on the regulated activity in breach of the condition imposed upon their registration.

The provider had recently appointed a new manager who had started working at the Elizabeth Anne Nursing home in February 2015. They were in the process of applying to be registered with the Care Quality Commission (CQC).

Since our last inspection the Nominated Individual had changed. A Nominated Individual is the person who must be employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity.

There was a system in place to monitor the service people received but this was not always effective. Regular quality checks were completed by the manager on key things, such as, care plans, fire safety equipment, the environment and medicines. General safety checks for electrical goods and equipment had been done. Audits had been carried out of the care plans, to make sure that they clearly described the care and support people needed. Shortfalls had been identified with the lack of detail and guidance in care plans and actions were set because the care plans did not give staff the information then needed to care for people safely. The shortfalls had not been addressed and care plans and risk assessments had not been reviewed and updated following the audits. Some of the care plans still did not contain all the information needed about the care, treatment and support people needed which left them at risk.

People's records did not contain accurate and up to date information, Staff did not have the guidance and information they needed to make sure that people received the care, support and treatment that they needed. People's care plans and other personal information were kept securely in a locked office to protect confidentiality and were located promptly when we asked to see them.

People were at risk of receiving unsafe and inappropriate care due to incomplete and inaccurate records. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that since the new manager had started working at the service they felt that there had been changes made for the better. Staff said, "We are now heading in the right direction. We now have someone who knows what they are doing and wants to make things better for everyone". These changes were at an early stage and the manager understood the need to maintain and sustain the changes.

They said that the manager was approachable and supportive and they could speak to her whenever they wanted to. People and staff told us the manager listened to what they had to say and 'sorted things out' if there were any problems. The staff said the registered manager always dealt with issues in a calm and fair way. On the day of the inspection people and staff came in and out of the office whenever they wanted to. There was clear and open dialogue between the people, staff and the manager. Despite the constant demands, the manager remained calm and engaged with people and the staff.

Staff said "I think we provide excellent care and we get lots of compliments from families. Things have got even better since the new manager came. It is a positive place to work now." and "Our residents are the most important thing. They deserve a happy and interesting life. I think we do that well."

The manager was available and accessible and gave practical support, assistance and advice. Staff handovers between shifts highlighted any changes in people's health and care needs but this was not always recorded in people's care plans. Staff were clear about their roles and responsibilities. They were able to describe these well. The staffing structure ensured that staff knew who they were accountable to. Regular staff meetings were held where staff responsibilities and roles were reinforced by the manager.

The manager and staff were clear about the aims and visions of the service. When staff spoke about people, they

Inadequate

Is the service well-led?

were very clear about putting people first. Staff talked about supporting people to be as independent as possible and maintaining people's dignity and being respectful. They said that there was good communication in the staff team and that everyone helped one another. They said that the service would only operate for the benefit of the people who lived in it with good staff team and management support.

People were listened to and their views were taken seriously. If any issues were identified they said these were dealt with quickly. Staff spent time with people finding out if everything was alright with the person and if they wanted anything. There were regular house meetings and people spent individual time with staff.

There were systems in place to regularly monitor the quality of service that was provided. People's views about the service were sought through individual meetings and reviews. Surveys and questionnaires had been sent to relatives, staff and visiting professionals. The outcomes of the surveys had been analysed. The results were mixed. In the relative's survey it stated 13% strongly agreed that their views were listened to and 63% agreed. 80% of people said that they would not know how to complain formally to the provider. The manager had taken action and had updated the complaints procedure so that it was available and accessible to people, their relatives and anyone else who came to the service.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not made suitable arrangements to protect people from abuse by not responding to allegations of abuse appropriately.** Regulation 13(1) (2)(3) (4)(b)

The enforcement action we took:
Cancellation of Registration

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 registered person had not taken action to make sure care and treatment was provided in safe way and ensuring that they were doing all that is reasonably practicable to mitigate any risks.** **People were at risk of not having their healthcare needs meet safely and quickly as staff were unsure and inconsistent in the actions they would take. The registered person had not made sure that staff had the competencies and skills to meet people's health care needs.** Regulation 12(1) (2) (a) (b) (c)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe.**

This section is primarily information for the provider

Enforcement actions

	Regulation 9 (1)(b)(c)(2)(b)(c)

The enforcement action we took:
Cancellation of Registration

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 The registered person had not taken proper steps to assess monitor and mitigate the risks relating to the health, safety and welfare of service users. Records were not suitably detailed and accurate. Regulation 17 (2) (b) (c)

The enforcement action we took:
Cancellation of Registration