Highcliffe House Limited

Highcliffe House Nursing Home

Inspection report

10 Cobbold Road
Felixstowe
Suffolk
IP11 7HQ

Tel: 01394671114
Website: www.highcliffehouse.com

Date of inspection visit:
08 March 2017
15 March 2017

Date of publication:
20 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 8 and 15 March 2017 and was unannounced.

Highcliffe House Nursing Home is a 30 bed residential and nursing care service providing care, treatment and support, including end of life and care and support for people living with dementia. On the day of our inspection there were 20 people living at the service.

There was a registered manager who was also the registered provider. 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.

At our previous inspections in May, July and August 2016, we found evidence of major concerns in relation to the clinical oversight of the service, insufficient monitoring of people with complex nursing needs and the overall quality and safety monitoring of the service. The service was rated as 'inadequate'.

We formally notified the provider of our escalating and significant concerns and placed a condition of the provider's registration to stop them admitting any further people to their service. We notified our stakeholders which included the Local Safeguarding Authority and the Clinical Commissioning Group (CCG).

At this comprehensive inspection, we found that with the support provided to the service from the local authority and the CCG, improvements had been made.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The provider had implemented systems to improve their quality and safety monitoring of the service including the clinical oversight of people with complex health care needs. However, further improvements were required in the monitoring of people at risk of malnutrition and wound management.

At two inspections carried out in the last year, May 2016 and August 2016 we found, ongoing concerns in relation to the management of people's medicines. At this inspection we found significant improvement with the implementation of improved systems for auditing and response to medicine administration errors.

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. However, not all incidents and accidents had been recorded and investigated

according to local safeguarding protocols and the provider's safeguarding policy.

Whilst we found some improvements, further work was required to ensure that the care planning for people who presented with distressed behaviours and the monitoring of catheter care, skin tears and wounds was effective at mitigating the risks to people's health, welfare and safety.

The service was clean and there were regular audits and systems in place to prevent the risk of cross infection. Environmental risk assessments had been updated to include regular safety checks of window restrictors, exposed pipework, bedrails and slip, trips and falls hazards.

Staff and the manager understood their roles and responsibilities with regards to the Mental Capacity Act 2005. Staff had received a variety of training relevant to their roles.

People's nutritional needs were assessed and they were supported to eat and drink according to their dietary needs, choices, and preferences. People were supported to access ongoing healthcare support. There were systems in place to ensure important information about people's health, welfare and safety needs were shared with the staff team.

People had access to clear information about how to raise concerns and complaints. There was a written procedure visible on noticeboards throughout the service . There was a suggestion box in the reception area, available to enable people to log any suggestions and concerns easily and anonymously if they chose. Annual surveys were carried out to ascertain the views of people and their relatives.

We observed some very caring interactions between staff and people living at the service. Relatives were positive about the improvements they had observed and in the culture of the staff group. Staff were observed to be kind and respectful in their approach towards people.

Auditing arrangements had been strengthened but further improvements were needed to the oversight of clinical care and accidents.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 consistently safe.

Staff had been provided with training and demonstrated their understanding of how to identify people at risk of abuse and the procedure for reporting concerns. However, not all incidents and accidents were recorded and investigated according to the local safeguarding protocols and the provider's safeguarding policy.

We found improved systems in place for the management of people's medicines and the auditing and evidence of actions in response to medicine administration errors.

People's likelihood of harm was reduced because risks to people's health, welfare and safety had been assessed and risk assessments produced to guide staff in how to mitigate these risks and keep people safe from harm.

The provider's recruitment procedures demonstrated that they operated safe and effective systems.

Is the service effective?

Good

The service was effective.

Staff and the manager understood their roles and responsibilities with regards to the Mental Capacity Act 2005.

People were supported to access ongoing healthcare support. There were systems in place to ensure important information about people's health, welfare and safety needs were shared with the staff team.

People's nutritional needs were assessed and they were supported to eat and drink according to their dietary needs and preferences.

Is the service caring?

Good

The service was caring.

Staff were attentive and caring in their interactions with people.

People's privacy and dignity was promoted and respected. Staff took account of people's individual needs.

Wherever possible people were involved in making decisions about their care and their relatives were appropriately involved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst we found some improvements at this inspection further work was required to ensure that the care planning for people who presented with distressed behaviours and the monitoring of catheter care, skin tears and wounds was effective at mitigating the risks to people's health, welfare and safety.

People had access to clear information about how to raise concerns and complaints. There was a written procedure available throughout the service on notice boards. Annual surveys were carried out to ascertain the views of people and their relatives.

Is the service well-led?

Requires Improvement

The service was not sufficiently well led.

There were improved clinical and safety audits. However, we identified further improvements were required such as; the monitoring and investigation as to how injuries had been acquired, recording of accidents and incidents, wound management and weight monitoring.

Highcliffe House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 8 & 15 March 2017 and was unannounced.

This inspection team consisted of two inspectors, one specialist nursing advisor with specialist experience in general nursing, a pharmacy inspector and one 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. The Expert by Experience had experience of providing care and support for an older person.

We carried out observations of the interactions between staff and the people who lived at the service. Prior to our inspection we spoke with stakeholders including commissioners of services.
We reviewed information available to us about the service, such as statutory notifications. A notification is information about important events which the provider is required to send us by law.

We reviewed the care records for 15 people who used the service. We also reviewed records in relation to medicines management, staff rotas, staff training matrix and other records related to the quality and safety monitoring of the service.

During our inspection we spoke with ten people who used the service, four relatives and seven staff including two nurses, the manager and the clinical lead.

Requires Improvement

Is the service safe?

Our findings

When we asked people if they felt safe living at the service, they told us; "It's fine here, nothing is too much trouble and I feel safe having other people around me", "We have buzzers in case we get stuck and they come pretty quick, when upstairs I very rarely wait and downstairs they are quite quick" and "I do feel reasonably safe." One relative said, "It is excellent and perfect for [relative] as far as I am concerned [relative] is safe. I have no qualms with the staff. I am here every day and made welcome, and stay for two to three hours."

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed.

However, not all incidents were recorded and investigated according to the provider's safeguarding policy. For example, where one person had sustained facial bruising on two occasions within the last month and an injury to their arm, no investigation had been carried out as to how this person obtained these injuries. No accident or incident report records had been completed. We noted that staff had recorded within daily wellbeing records one incident of bruising and a skin tear on the same day. Staff had also recorded that this person had physically resisted when care staff had attempted to support them with personal care. We were concerned that no action had been taken by the clinical lead to acknowledge and investigate how these injuries had been sustained. This meant we were not assured that the provider had effective systems in place to identify the risk of potential abuse and taken preventative actions, including escalation, where appropriate. We discussed our findings with the provider and following our inspection raised a safeguarding alert with the local authority.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at systems in place to monitor the effectiveness of pressure relieving equipment such as mattresses. There was a system in place to check that the pressure of the mattress related to the actual weight of the person. The system in place consisted of monthly monitoring whereby a nurse placed stickers on the mattress motors to evidence the date of their checks to ensure the pressure setting was correct for the weight of the person. However, the amount of stickers left on the motors had obscured the previous settings monitored. The consequences of leaving so many stickers on the motors meant that the previous readings could not been seen and if action had been taken, this was not recorded. Pressure mattress motor settings were not being renewed monthly as people were weighed in response to any changes in people's weight.

We also noted that there was no record in the residents care plan as to what the mattress settings should be set at to provide guidance for staff as to the optimum pressure relief. This meant the current system was ineffective, as it demonstrated a system that had been started but then not continually monitored

effectively.

Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. We found one pressure relieving mattress motor had been set for a person weighing 135kg when their actual weight recorded in January 2017 was 63.9kg. This meant the air cells within the mattress would inflate to a high pressure and will only deflate a small amount as the mattress is expecting to support a greater weight. The effect of this is a hard, uncomfortable surface for a lighter weight person to lie on and undermines effective pressure relief on the person's body. The impact for people where pressure mattresses were set incorrectly placed them at risk of further pressure damage. Following our feedback the provider wrote to us to inform us that they had checked all mattress settings and ensured these were set at the pressure appropriate to the weight of each person. They had also reviewed their system for recording and implemented a register to be included alongside their monthly equipment checks.

Risks were identified and there were tools in use such as Malnutrition Universal Screening Tool (MUST) and Waterlow assessments which would identify people at risk of acquiring pressure ulcers. Where people had been assessed as at high risk of malnutrition action plans were in place guiding staff to carry out weekly weight monitoring. However, MUST assessments where people were scored at high risk continued to be carried out monthly. This contradicted the guidance provided in the MUST local policy. We also found that weights recorded within monthly MUST tool assessments did not always relate to the weights recorded in weekly weight records. Where the MUST tool record required action plans to be recorded, generic comments to guide staff had been recorded such as; 'as per dietician care plan'. However, it was not always possible to find what the dietician care plans was and discussions with staff evidenced they were not always clear as to the steps they should take to mitigate risks to people from inadequate nutrition. We discussed this with the provider who told us they had taken immediate action to rectify this.

Care plans contained detailed moving and handling plans including guidance for staff as to what type of hoist sling to use. Personal evacuation plans had been produced to guide staff in steps they should take if in need to evacuate the building in the event of an emergency. However, we observed staff assisting one person using an electric hoist. We noted that staff used a medium sized toileting sling but we were concerned that the sling was too large for the weight of the person. Following our intervention staff provided a smaller more appropriately sized sling.

We found environmental risk assessments had been updated to include regular safety checks of window restrictors, exposed pipework, bedrails and slip, trips and falls hazards.

At our last two inspections we found continued, ongoing major concerns in relation to the management of people's medicines. At this inspection we found improvements had been made with some further work required. We looked at the systems in place for managing medicines; spoke to staff involved in the administration of medicines and examined 13 people's medicines administration record (MAR) charts.

Administration was recorded clearly on MAR charts which were provided by the pharmacy. There were no omissions in the administration records. All medicines were available and suitable for use and there was a clear system of ordering to ensure that medicines were received and checked ahead of time. Any handwritten additions or changes to the MAR charts had been checked by another member of staff.

Medicines were stored safely and securely, in locked medicine trolleys or cupboards within a secure clinic room. The temperature of the clinic room had previously been identified as being too warm and the home were in the process of installing an air conditioning unit. Medicines that require additional controls because

of their potential for abuse (Controlled drugs) were stored appropriately and checked regularly. Medicines requiring cold storage were kept within a monitored refrigerator in a separate area. However, we found the refrigerator was not being monitored adequately and the maximum temperature recorded on the day of inspection was 20C. The maximum and minimum were not being routinely monitored.

There was a photograph of people for identification purposes available as part of their medicines records. People's allergies were clearly recorded and their preferences as to how they liked to take their medicines were available to guide staff. There were three people who were administering their own medicines and comprehensive assessments had been completed to ensure this was done safely.

Medicines that are required to be administered separate from breakfast and any other medicines were being administered correctly by nursing staff at the time of our inspection but documentation on the MAR chart did not reflect this.

Protocols for the administration of 'as required' medicines were available. These protocols provide guidance as to when it is appropriate to administer medicines that are not required regularly such as analgesics, inhalers or sleeping tablets. If there was a choice of how much medicine to give, or a variable dose such as warfarin, the records clearly showed what had been administered.

Medicines that were applied as patches were recorded appropriately on separate charts, although it wasn't clear whether staff had rotated the site of patch application in line with the manufacturer's instructions. Medicines being applied topically such as creams and ointments had clear records in the form of body diagrams so that staff knew where and how often these needed to be applied.

Homely remedies were available for administration to allow staff to respond in a timely manner to minor ailments and it was clearly recorded on MAR sheets when people had received them.

There was a good system of communication in place with the visiting nurse practitioner, allowing identification of non-urgent medicines issues, which she reviewed and actioned on a weekly basis.

Medicines were being administered in a covert manner to one person living at the service. Covert administration involves hiding medicines in food or drink. There was evidence that all health care professionals and a family member were in agreement and this was in the person's best interests. One other person's medicines were being crushed before administration at their request and full instructions were available for staff to ensure they received their medicines appropriately.

Staff knew how to report a medicine incident and we saw evidence of incidents that had been reported. The was a programme of audit in place, both in-house and by the external pharmacy supplier, which allowed the clinical lead to identify any problems with medicines in a timely manner. Staff had undergone medicines training.

People gave us mixed views regarding the numbers of available staff at all times to meet their needs. Comments included; "There are staff around most of the time when you need them", "The night staff come quicker than the day staff", "I ring the bell and wait sometimes 15 minutes or more, lunch time is very busy. I am not at risk at all and quite happy here" and "In the mornings they have not got enough staff, not got two for each floor. I have two staff but sometimes only one appears and I always ask where is your partner as I feel safer with two."

The manager told us that they had only one full time health care vacancy and a full complement of nursing

staff.

Nursing staff told us that staff were allocated flexibly according to the fluctuating needs of people. Communication books showed us that staff were allocated to a specific area of the service each day according to people's needs. One member of care staff told us, "We sometimes struggle in the mornings to meet people's needs. You want to give everyone time but it's hard as you haven't always got the time. There are a number of people who need two staff at a time."

The provider used a dependency tool and we noted that the majority of people had been rated as having 'medium' dependency needs. However, it was not clear how this tool related to the allocation of the staffing numbers provided.

The service recruited staff in a way that protected people. A review of staff recruitment files showed us that application forms had been completed which identified any gaps in applicants previous work history. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this setting. References and DBS checks had been confirmed before staff started working at the service. This meant that the manager followed safe recruitment practices, with steps taken to assess that staff employed were of good character, competent and had the necessary skills for the work they were employed to perform.

We reviewed the systems in place to ensure that clinical equipment such as such as blood pressure monitors, syringe driver, nebulisers, suction machines, glucometers and thermometers were kept clean and well maintained. We saw that there was a system of regular weekly checks on equipment and service agreements in place

There were systems in place to prevent the risk of cross infection. We saw that wall mounted non-touch dispensers of hand wash and alcohol hand gel had been placed around the service. Bins for clinical waste were in place. Clinical waste was appropriately disposed of. We also saw that staff had access to plentiful supplies of personal protective clothing such as disposable gloves and aprons, with easy access for staff. However, we noted that the casing to the Apomorphine pump in use was not clean. We recommended to the clinical lead that this be cleaned regularly as this posed a risk to people of acquiring an infection.

Good

Is the service effective?

Our findings

Nursing, care, kitchen and domestic staff told us they had received a variety of training relevant to their roles. This included moving and handling, diversity, catheter and stoma care, fire and health and safety. Staff told us health and safety training included information about what to do in an emergency and responding to the needs of people at risk of choking. Some of the training staff received was provided via eLearning but also other training was provided within a group setting from specialist trainers. The local authority provider support team had also supported the staff team with training to support improvement of the service.

The provider showed us a record where they monitored checks on nursing staff registration and when nurse re-validation was due. One nurse told us their re-validation was due in 2019 and they were working towards this.

Staff told us they received regular supervision to discuss their performance and plan for their training needs. Daily handover meetings took place at the beginning and end of each shift. This meant staff had the opportunity to receive updates as to people's current care needs.

Staff recently employed told us, "This is a good home and a nice place to work. I was supported to work alongside other more experienced staff before I worked alone." Another said, "I was able to shadow other staff for as long as I needed to feel confident." They described their induction where they viewed training videos on areas such as health and safety and infection control. They told us they did not know what the Care Certificate was. This is a set of induction standards that health and social care workers adhere to and evidence their competency had been assessed and certified as competent. They also told us they had just started to work towards achieving their Quality Care Framework qualification.

Staff and the manager understood their roles and responsibilities with regards to the Mental Capacity Act 2005. We checked staff understanding of the Mental Capacity Act 2005 (MCA). The MCA sets out what action providers must take to protect people's human rights where they may lack capacity to make decision about their everyday lives. Staff confirmed that they had received training in understanding their roles and responsibilities with regards to the MCA and Deprivation of Liberty Safeguards (DoLS). Care records showed us that people's capacity to make decisions regarding their health, welfare and finances had been assessed. Where people were subject to a DoLS authorisation this was clearly documented in their plan of care. Where people had made arrangements to appoint a lasting power of attorney this was documented within their care and support plans.

People were supported to eat and drink according to their dietary needs, choices, wishes and preferences. Food was presented well, appetising to look at and people were provided with a choice of what they ate and where they ate their meals. We observed staff checking throughout the day to ensure people had access to drinks. People told us they were satisfied with the support they received from staff and were provided with enough to eat and drink. One person told us, "Food is lovely, we have lovely tea parties, they do well and we

can invite family."

We observed a member of staff supporting an individual who had a pureed diet. The meal was nicely presented with food items separately pureed. The staff member chatted to the person as they supported them at an appropriate pace enabling the person time to digest their food without being rushed. People told us that if they did not like what was on the menu they were offered alternatives such as sandwiches and omelette. Where people at risk of losing weight and who required fortified food including prescribed cream shots and milk shakes, records however did not always evidence that these had been provided and consumed.

There were systems in place to ensure important information about people's health, welfare and safety needs were shared with the staff team. This included daily handover and regular staff meetings. We saw from a review of handover records that staff had been supported with guidance to enable them to meet people's needs and evidence when tasks had been completed which also provided an audit trail for management reference.

One person with a hearing aid in place told us that staff regularly supported them to change the batteries when needed. Another person said, "I had to go to the hospital for my eyes, the staff did my nails specially. You can choose what doctor you have, and the Chiropodist comes regularly." One relative told us, "You can speak to the owner, and they phone and tell me when [relative] has a hair appointment, seen the Dentist, they call the GP when needed and tell you the outcome of their visits. I had four phone calls one day keeping me up to date; they have [relative's] best interests at heart.

Care plans included details of planning to support people to maintain their health and wellbeing. For example, support for people with complex health conditions such as; Parkinson's and, diabetes. There was evidence of when people had been supported to access advice and support with regular health reviews with healthcare specialists and when they had attended appointments. For example, with their GP, dentist, and dieticians. We saw that regular clinical observations were carried out such as checks on people's blood pressure.

Good

Is the service caring?

Our findings

We received only positive feedback about the service. People told us they were happy with the care and support staff provided to them on a daily basis. They told us they were treated with dignity and respect and that staff were always kind and caring. One person told us, "They are all kind and helpful. We choose what we want and when we want to do things. They respect my choices about how I want to live my life even though I am limited in what I can do." One relative told us when asked if they were involved in the planning of their relative's care, "I am involved in this and mainly discuss this with the Nurses." Another relative told us, "Brilliant home, loving care is paramount, and [relative] has been here over two years, and gets consistently loving care and is much better off for being here."

We spent time observing interactions between staff and people who used the service within the communal areas. We saw that staff were respectful and spoke to people in a kind manner. For example, we saw that when staff supported people to and from the dining room in wheelchairs, they did so in an un-hurried manner and chatted to people. During the meal time we saw staff offering choice and respecting people's wishes. We observed people to be at ease and comfortable when staff were present and people were treated with warmth and kindness.

We observed staff offering people choice. For example, we observed one member of staff talking to one person; "You like the colour pink, do you want to put that on today or wear it for the coffee morning tomorrow, OK, I will make a note for them to pop that on for you tomorrow."

Care plans described people's choices and preferences, likes and dislikes including how people liked their care to be provided. Care plans contained specific guidance for staff in how best to deliver care in a respectful and dignified manner. People told us they were treated with dignity and that their privacy was respected by staff. Comments included, "The staff are all lovely, I cannot fault any of them, they are all very nice. They look after me very well and with respect." And "When I have help with a bath the girls are so lovely to me and make me feel comfortable."

Care plans were personalised and contained information for staff about people's life history, likes and dislikes and their future decisions and preferred plans of care. We saw that care plans also contained information which outlined how people liked to spend their day. People were supported and encouraged to maintain links with their family and friends.

Requires Improvement

Is the service responsive?

Our findings

Whilst we found some improvement at this inspection further work was required to ensure more effective monitoring of people's needs in relation to their catheter care, skin tears and wounds.

We asked nursing staff and the clinical lead how they recorded accurate measurements and if they took photographs of wounds so that they could be assessed and reviewed. They told us wounds had not been photographed and measured accurately. We asked how nursing staff knew when dressings required changing. They told us this information was recorded in the communication diary and on handover records. In relation to the care of two people who required ongoing wound dressing changes, we found that this information had not been put in the diary or on the handover record sheet. We found for one person there was conflicting information as to the size of the wound that required regular dressing. The type of dressings required had not been recorded within care plans. This meant that we could not be assured that wounds were, being monitored effectively so that any progress or deterioration was identified and addressed.

We looked at the planning of care to meet the needs of people with an indwelling catheter. Staff had recorded the dates of catheter insertion and the regularity of bag changes required. We asked nursing staff where they recorded the date of the next catheter change, as it was not recorded in the care plan. They told us this was recorded in the staff communication. We noted that this was not always recorded as required. The manufacturers of the sterile catheters have a label on the inner packaging that is easily peeled off so that it can be put in peoples care records. This gives the type and size of catheter, balloon size, manufactured date and batch number and the expiry date. This meant that if there was a problem with the catheter it could be tracked back to the manufacturer and the batch involved, it is also a complete record for the nurse to refer to when required for monitoring. This did not assure us that best practice protocols had been followed. We advised nursing staff including the clinical lead the importance of having this information effectively recorded for ease of reference and easily located if catheters are needing to be changed more frequently and the reasons for this. Later the nurse on duty told us they had been informed that they should record on the MAR chart when catheters are next due. We advised that this was not the most effective system as the MAR charts are changed every four weeks and if staff have not written on each new sheet when the catheter is due, this date will not be noted.

We noted that the Do Not Attempt Resuscitation (DNACPR) records in place for one person provided staff with details concerning relatives contact information but no other information as to any pacemaker. We had earlier noted information sheets from the NHS choices website concerning pacemakers in this person's care records. We asked the nurse on duty if the person had a pacemaker and they said, "I do not think so." We asked another member of staff who said they were not sure and then looked in the person's care plan. They found within the person's moving and handling care plan recorded that they did in fact have a pacemaker fitted. We advised nursing staff the presence of the pacemaker should be highlighted in care plans including end of life documentation so that accurate information is given to the doctors and funeral directors as this would present significant risk of harm and would be vital information to be aware of following death .

Staff recorded care provided and any interventions within a daily, 'Resident Well Being' chart. This included

sections for staff to evidence the type of support provided. For example, personal care, access to drinks provided, call bell within easy reach as well as when medicines such as creams and lotions had been applied. We noted one column for staff to record when they had supported people to reposition in bed to prevent the risk of them acquiring a pressure ulcer. We saw that staff had used a code 'RP' which did not relate to the example of codes provided. The clinical lead told us this was an abbreviation for 'repositioned'. However, it was not evident where people had been repositioned to and from. Such as right to left or back to side. We saw that for one person they remained positioned on their back for the whole day of our inspection but staff had recorded 'RP'. We recommended that all staff recorded the actual position of the person at each check and monitored appropriately as this lessens the risk of pressure ulcers and also aids the normal expansion of the chest and lungs to reduce the risk of chest infections. Immediately following our inspection the provider informed us they had taken action to rectify this and staff had been provided with instruction in how to record appropriately.

The shortfalls we identified demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people living with dementia presented with distressed behaviours which may challenge others, we found specialist advice had been sought. Behavioural monitoring charts were in place for staff to record a log of incidents which would help determine possible triggers for analysis. However, we found that these had not been consistently completed and we could not see evidence of monitoring and analysis having been completed. For example, we observed interactions and noted daily care notes recorded two people who appeared to present with distressed behaviours when they were provided with personal care. Staff told us they were not sure as to what if any strategies were in place to alleviate these people's distress other than the use of medicines prescribed and walking away and trying again later. Further work was needed to provide staff with specific guidance in how to respond to people living with dementia who presented with distressed behaviours which may challenge others

We asked nursing staff how they carried out checks to ensure that people confined to bed were protected from the risk of health complications such as the risk of impacted bowels. They told us bowel movements were recorded on daily well-being records and monitored every seven days. We observed staff were regularly recording when people had bowel movements and used the Bristol Stool chart to record type. We asked if nursing staff reviewed these records and was told a senior health care assistant had responsibility for this task. We recommended that seven days before a review was too long and if interventions were required these may need to be implemented earlier.

One person told us when asked what activities they were provided with, "I like to do colouring, we have the singer's visit who are lovely and we sing and dance, they pop my coat on and I go in the wheelchair to the shops and we go to where I used to work and I say hello to them all. I sit outside in the summer and we have meals out there sometimes." Another told us, One person told us, "I can go out into the garden in the summer and can have a walk down to the sea."

The provider employed staff designated to provide one to one and group activities. We observed during our inspection one activity staff member who spent the majority of their time based in the communal lounge. They told us there was no definitive plan of activities in place as any plan was subject to constant change.

We noted that there continued to be a number of people who stayed in bed without any clear reason as to the reasons why. There was limited information available to guide staff and to assure us that their needs for social interaction and mental stimulation had been assessed with action planned to meet their needs. We discussed this with the provider who told us they had plans to improve and provide further training for staff

in providing meaningful interaction and activities that would meet people's needs and in particular meeting the needs of people living with dementia.

People had access to clear information about how to raise concerns and complaints. There was a written procedure available throughout the service on notice boards. There was a suggestion box in the reception area, available to enable people to log any suggestions and concerns easily and anonymously if they chose. A recent survey had been completed to ascertain the views of people who used the service and their relatives. The majority of responses received were positive. For example, 'Staff are kind and respectful', staff go above and beyond the call of duty' and 'Some of the staff really care, others just do a job.'

Requires Improvement

Is the service well-led?

Our findings

At our previous inspections in May, July and August 2016, we found evidence of major concerns linked to a lack of effective management and clinical oversight. The issues included the management of people's medicines, insufficient monitoring of people with complex nursing needs and the overall quality and safety monitoring of the service. This meant that Quality and safety monitoring processes were ineffective and did not identify the shortfalls which put people's health, safety and welfare at risk. We took urgent action in response to our findings to stop the provider admitting anyone new to the service by amending their conditions of registration.

At this inspection we found improvements had been made. There were improved clinical audits which included the monitoring of; falls, food and fluid intake for those at risk of inadequate nutrition, equipment checks and the audit and management of medicines errors. Other quality audits included a review of care plans and safety of the premises. We saw documentary evidence that these took place at regular intervals and any actions identified were addressed with timescales for actions to be completed. However, we identified further improvements were required such as; the monitoring and investigation as to how injuries had been acquired, recording of accidents and incidents, wound management and weight monitoring.

Staff spoke positively about the support they received from the management of the service. They told us, "The manager's door is always was open and that she comes around the home now and again." And, "We work well as a team here. We have a happy working atmosphere here, in the kitchen and the care staff seem happy, any problems the manager sorts out and our relationships with the Kitchen Manager is good."

Staff told us they had regular access to staff meetings and supervisions where they could air their views. They told us these meetings were informative and helpful at improving communication across the service. Staff said they could make positive suggestions and people could speak up if they had concerns or ideas. We saw that staff meetings including daily handover meetings were held on a regular basis so that people were kept informed of any changes to people' well-being, needs and work practices or anything which might affect the day to day management of the service.

The provider who is also the manager told us they had recently signed up to the 'My Home life' leadership programme. My Home Life is a UK-wide initiative that promotes quality of life and works with provider's and manager's to develop good practice in their care homes and support delivery of positive change for people living in care homes for older people. The provider told us they were benefitting from this initiative, learning from others sharing of knowledge and group support.

Relatives spoke of the improvements since the last inspection in relation to; staff morale and the manager's prompt responses to concerns and complaints. Comments included; "The management is delivering on what they are saying", "Things are settling." And "I cannot fault it, well run, professional and nothing is too much trouble, I have no complaints, the manager's door is open and you can go to her with any problems." And another, "Staff are first rate, polite and professional and attentive, they care for [relative's] needs with a smile on their faces."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person Centred Care The provider did not always provide staff with the information they would reasonably need for the purposes of providing care for people in relation to wound care, repositioning and pacemakers.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment The provider failed to investigate incidents where people had sustained injuries and to identify any potential abuse or improper treatment.