CCA & Mrs C Bolland

Laurel Bank

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Laurel Bank Nursing Home provides accommodation and nursing care for up to 37 people. The property is a converted house which has been extended. Accommodation is spread over two floors. There are numerous communal areas such as lounges, a dining room and an enclosed garden.
At the last inspection in September 2014 the home was compliant with the standards we looked at.
We inspected the service on 6 July 2016. On the date of the inspection 29 people were living in the home.
A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
People and relatives provided positive feedback about the service and told us people were well cared for, treated well and that individual needs were met. We found the management team were very 'hands on' and regularly got involved in care and support. This created a friendly and pleasant atmosphere within the home and we saw some examples of good care and support being delivered. However we identified a number of unacceptable risks which were not adequately controlled. As many of these had not been identified by the service, we concluded there was a lack of proper oversight of the service and systems to assess, monitor and improve the service were not fit for purpose.
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People told us they felt safe living in the home and said they had never witnessed anything of concern. In most cases, risk assessments were in place which considered risks to people and provided staff with guidance on how to provide appropriate care. However we identified where bed rails were in situ, the risks associated with these had not always been assessed.

Medicines were not safely managed. Medicines were not always stored securely and some of the practices we witnessed during the medicines administration round were unsafe.

There were sufficient quantities of staff deployed to ensure people were responded to in a prompt manner. Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. However staff were not all up-to-date with key safety related training.

The premises had a homely feel and people were encouraged to personalise their bedrooms. Key safety checks were undertaken on the gas, electrical and lifting equipment. However water temperatures were not monitored to ensure they were safe and we found a number of outlets where water was not warm enough.

People said staff had the right skills and personal attributes to care for them. However training had been provided in an inconsistent manner with a number of staff not receiving training in key subjects. Some staff had not received timely supervision or appraisal.

Most people praised the food and said it was tasty and there was sufficient variety. Where people were assessed as being nutritionally at risk, appropriate action was taken to address.

The service needed to take action to ensure it was working within the legal framework of the MCA and evidence that decisions made for people without capacity were done as part of a best interest process. Staff we spoke with did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) and who had one in place.

People's healthcare needs were assessed by the service and plans of care put in place. Care was co-ordinated with a team of external health professionals where required.

People told us staff were friendly and treated them well. We observed that staff knew people well and understood people's likes, dislikes and personal preferences. However we identified a number of working practices which demonstrated people were not consistently treated with dignity and respect or in a fair manner.

People's needs were assessed and plans of care put in place. These were well understood by staff. However some care plans needed more detail to demonstrate the exact nature of the care required.

An activities co-ordinator was employed and provided people with a range of activities. A new activity plan being recently been agreed to increase the variety of activities available to people.

People and relatives expressed a high level of satisfaction with the service. A complaints policy was in place and we saw evidence it had been followed.

Audits were undertaken to help assess monitor and improve the service. However many of these were not sufficiently robust as a number of risks we found had not been identified by the service.

Incidents and accidents were recorded and we identified no concerning trends. However there was a lack of evidence of preventative measures put in place following incidents.

We found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Registration Regulations 2009. You can see what action we asked the provider to take at the back of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely. We witnessed unsafe practices and medicines weren't stored securely.

Staff had not consistently received key safety related training.

There were sufficient quantities of staff to ensure people received prompt care and regular interaction.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People and relatives praised staff and said they had the correct skills to care for them. However training, supervision and appraisal had not been provided to staff in a consistent way.

People were provided with a variety of food and were supported appropriately to ensure their nutritional needs were met.

Action was needed to ensure the provider was fully acting within the legal framework of the Mental Capacity Act. (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives praised staff and the management and said staff were kind, caring and valued them. However we noticed some working practices did not always preserve people's dignity.

Staff knew people well and had sought information on their lives and personal history to help provide personalised care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and care plans put in place

although some of these required more detail.

Care plans were regularly reviewed but there was a lack of involvement of people and their relatives in this process.

Complaints were appropriately managed and people expressed a high level of satisfaction with the service.

Is the service well-led?

Inadequate

The service was not well led.

People and relatives praised the management team and said they were friendly and approachable. Staff told us morale was good and we observed a nice atmosphere within the home. However we identified a number of practices were rather institutionalised rather than based on person centred approaches.

Audits were undertaken to assess monitor and improve the service. However many of these were not thorough enough as key issues had not been identified.

There were a lack of systems in place to seek people's feedback and involve them in the running of the service.

Laurel Bank

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 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 6 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 13 people who use the service, four relatives, four care workers, the cook, the activities co-ordinator, the deputy manager and registered manager and the provider. We observed care and support in the communal areas of the home.

We looked at elements of four people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider and notifications. Prior to the inspection, we asked the provider to complete 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. This was completed and returned to us in a prompt manner.

As part of the inspection we also contacted the local authority and clinical commissioning group (CCG) to ask them for their views on the service.

Inadequate

Is the service safe?

Our findings

Medicines were not always administered safely or with regard to people's dignity. We observed the nurse administering medicines signing the medicines administration record (MAR) on three occasions before the medicines had been given. This was inaccurate recording and made a presumption that the medicines had been taken by the person.

We observed the staff member administering medicines signing the MAR to indicate a person's refusal to take one of their prescribed medicines. We questioned the staff member about this, since no tablet had been returned to the trolley. They agreed the person had not refused and explained they were out of stock of the medicine. We checked the MAR and saw staff had signed the person's apparent refusal since the start of the current MAR on 20 June. When we asked why the stock had not been replenished, the staff member told us the medicine had been discontinued. However, we could find no record in the medicines file or in the person's care records to support this. We saw a number of other people's medicines had been noted as 'refused' since 20 June without documented reason. We concluded the service was failing to keep accurate or up to date records of people's medicines or having people's medicines reviewed in an accurate and timely manner in order to ensure the MAR charts were up to date and relevant.

We found medicines were not always stored securely or safely. On a number of occasions we saw the nurse administering the medicines leave the medicines trolley doors either ajar or unlocked with the keys in the door whilst taking medicines to people sitting in the adjoining room.

Medicines trolleys were stored in a medicines room when not in use and securely fastened to the wall. The medicine fridge was kept in the same room and did not have a lock. On three occasions during the day of inspection we found this room unlocked without staff in the room. Medicines awaiting collection for disposal were stored in a padlocked cupboard in the room that contained the controlled drugs cupboard. However, we checked three times during our inspection and discovered the padlock was open and the room door had been left unlocked. This meant these medicines were not stored securely.

We observed the medicines fridge appeared to be defrosting and was dripping water inside, over the boxes containing medicines. We saw a tea towel placed at the bottom of the fridge to catch drops. The fridge temperature monitor did not appear to be functioning accurately since the displayed temperature reading was constantly altering. This meant we were not satisfied that medicines were safely stored in the medicines fridge or at the correct temperature and an accurate record of the temperature was not being recorded. The registered manager told us they would ask for a new fridge from the provider.

Some medicines were given 'as required' (PRN). There was a PRN policy in place and we saw some people had PRN information sheets in the medicines file which stated the dose and reasons for administration. We saw the person using the service had signed the PRN sheet where possible and there was a photograph of the person on the sheet. However, some people's PRN medicines noted on the PRN sheet were not entered onto the MAR chart. This meant there was no record of some people being given their correct PRN medicines. We concluded the service was not following safe practice in the management of PRN medicines.

We saw no indication on the MAR chart or PRN sheet to suggest where some topical creams should be applied, with instructions such as, 'use as required for external use only.' Body maps were not used to indicate areas for cream application. Some topical creams and eye drops we checked did not have the opening date written on them to indicate when the medicines would expire. Some people's eye drops also had, 'as required' as an instruction which would not indicate under what circumstances, how many drops or for which eye the drops should be used.

On two people's MAR we saw staff had written where the GP had discontinued a medicine. However, there was no signed instruction from the GP on the MAR, in the person's care plan or information on the daily notes to confirm if this was the case.

We carried out a random audit of boxed medicines and we unable to reconcile the stock amounts due to some numbers not being recorded upon delivery from the pharmacy, or stock balances not carried over from the previous month. This meant systems were not in place to properly account for medicines. We checked one person's prescribed eye drops. We saw they had two sets of the same eye drops in the medicines fridge; one had been opened on 21 June and one on 17 May. The eye drops opened in May had been put in the 'unopened' tray in the medicines fridge. This meant that out of date medicines could have potentially been administered.

In another instance, we observed the nurse administering medicines open the dossette container into their hand before placing into the medicine cup. No gloves were worn during the medicines administration. This was in contradiction to the provider's medicines policy which stated, 'Place the required dosage into a medicines measure (liquids) or plastic cup (tablets/capsules) without touching the medicine.'

We discussed our concerns about safe management and handling of medicines with the registered manager. They agreed with our findings and they needed to put a more robust system in place.

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

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drugs were stored in a locked metal box inside a locked metal cabinet. We saw that where controlled drugs had been given, these were checked and signed by two staff members.

In most cases, risks to people's health and safety were assessed and appropriate risk assessments put in place. For example risk assessments were in place which covered nutrition, mobility and falls and skin. These provided guidance to help staff provide safe care. However in two cases where people had bed rails in situ there was no risk assessment in place detailing how the risk associated with bed rails was being controlled .

During observations of care and support we observed another area of concern. A bucket containing bottles of cleaning solutions was left on the floor of one of the offices which was open and therefore accessible to people who used the service.

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

Overall we found the home to be a clean and hygienic environment. We observed staff using aprons and

gloves when delivering personal care. However during our walk around the premises we saw one damaged pressure relieving cushion which had lost its lamination and therefore could not be cleaned properly. We drew this to the attention of the registered manager who immediately organised for this to be disposed of.

We conducted a tour of the premises and saw furnishings were comfortable and homely. There were two lounges, a dining room and a large conservatory for people to sit in, with one of the lounges being used as a 'quiet' lounge. We saw people had free access to the garden which was tidy and well kept. People's rooms contained matching furniture and people were encouraged to personalise their room as much as possible. Some paintwork and decorations looked tired and needed refreshing, such as some bedrooms where the bed frame had rubbed against paintwork, or doorframes where the paintwork was badly chipped. Bedroom doors upstairs were fire doors which should remain closed for fire safety reasons. When we walked around the property, we saw two bedroom doors were propped open, one with a commode and one with an armchair.

The service employed a part-time maintenance person and jobs required were recorded in a maintenance book. Inspection of fire equipment, 5 year hard wiring test, gas certificate, portable appliance testing on electrical items and servicing for lifts and hoist were documented. The registered manager told us some of the emergency lighting system was not functioning correctly but the electrical contractor used would be attending to this.

The service had recently installed combi boilers with a service contract. However when we tested the hot water temperatures in the taps we found a wide variation in temperatures. For instance, in two of the downstairs toilets we were not able to get any warm water from the wash basins despite running the tap for several minutes, yet in another the water was of reasonable warmth. We asked to see the water temperature checks and saw no checks had been carried out since 2015. The registered manager told us they had been told this was not needed after the new boilers and valves had been installed. This was contrary to what was documented in the home audit which stated checks had been done and were within limits.

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

People we spoke with told us they felt safe living in the home and in the company of staff. One person told us, "definitely feel safe here," and another person said, "I feel safe."

Staff had an adequate understanding of safeguarding matters and how to identify and act on allegations of abuse. People and relatives we spoke with told us the home was safe and they had never witnessed anything of concern. People told us staff treated them well. For example one person told us, "I like it here, they are all very friendly and nothing is too much trouble for them." Another person told us, "It's alright, I like it. The staff, they look after us well." People said they felt able to raise any concerns with the staff or management and action would be taken to address any concerns.

We spoke with the registered manager about safeguarding matters. We found there had been no recent safeguarding incidents, although the manager's answers demonstrated they were aware of the correct procedure to follow should an incident occur.

We concluded there were sufficient quantities of staff deployed by the service to ensure people received safe care. The registered manager and deputy manager led a team of nurses and regularly worked nursing shifts themselves. The home ensured there was at least one nurse on duty at all times, and this was often two which allowed the second nurse to undertake care reviews and other administration tasks. Four or five care

staff were on duty throughout the day and two at night. People told us there were always enough staff to ensure they received prompt care. For example one person told us, "If I have to ring my buzzer in the night (or day) they come really quickly." During observations of care we saw staff were visible and able to promptly respond to people's individual needs. Staffing levels allowed staff the time to chat with people and provide social interaction as well as completing care based tasks. The service was fully recruited in terms of care staff and had one night nursing vacancy. This shortfall was being managed by using the same agency nurse to ensure consistency and familiarity.

There was a low turnover of staff which allowed staff to become knowledgeable and familiar with people.

However we found some key safety related training was not up-to-date. For example only two out of six nurses and five out of twenty care staff had received fire safety training and no staff had received training in epilepsy despite two people living at the service having epilepsy. The deputy manager told us they would ensure epilepsy training was provided to staff in the near future.

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

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. Staff were required to complete an application form, attend an interview, provide satisfactory references, details of any previous qualifications and undertake a disclosure and Baring Service (DBS) check. On reviewing staff files we found the required documentation was present demonstrating these checks were carried out. Staff we spoke with also told us these checks on their character were carried out.

Requires Improvement

Is the service effective?

Our findings

People and relatives spoke positively about the effectiveness of the service. One relative told us, "My wife has been here for over two years and was in a couple of other places before here. This is much better, I have no complaints." Another person's relative commented, "There has been significant mental improvement since [person's name's] been here and an improvement in her sociability." Another person told us, "My relative has been in quite a few places and this is the best."

People and relatives we spoke with told us they received effective care provided by staff with the right skills and knowledge. Care was provided by a stable staff team. For example all care staff had worked at the provider for over a year. This low turnover allowed staff to understand people and how to meet their individual needs. Staff we spoke with and observed demonstrated good knowledge about the people they were caring for, and how to provide a good level of attentive care.

We found improvements were needed to the provision of training, supervision and appraisal. This had been identified by the provider and a training matrix, and supervision planner for 2016 had recently been developed to improve this aspect of the service. However at the time of the inspection there were a number of shortfalls which had yet to be addressed.

New care staff without previous experience received induction training from an external training provider which covered areas such as safeguarding, manual handling and nutrition although the home was not working to the Care Certificate, which is a nationally recognised standard of induction training for new staff. New staff with previous experience or qualifications did not always undergo the induction process; however there was no process in place to formally assess their skills and knowledge to determine the level of induction training needed. The deputy manager told us that new staff also undertook a local induction to the building, policies and ways of working. However in two of the staff files we looked at there was no evidence of an induction to the building and local ways of working.

Many staff had achieved recognised qualifications in health and social care. We looked at the training matrix which showed most staff were up-to-date in key topics such as safeguarding and manual handling. However there were a number of gaps where staff had not received training in subjects such as fire, challenging behaviour and dementia. For example only six of 20 care staff had completed training in dementia awareness. We observed two incidents where people displayed behaviours that challenged, where staff failed to adequately explain or calm people who were distressed. One such incident related to transferring one person from their wheelchair by to a chair with a harness. The two care staff who were transferring the person did not explain fully why they were using the harness or try to calm the person when they became upset; they just continued with their actions. The person became more distressed and threw the harness away. Whilst they were not in any way unkind or uncaring, staff seemed unclear on how to offer the necessary assurance. We saw some staff had received training in behaviours that challenged; however many staff had not.

Specialist training was provided on a periodic basis. For example some staff had received training in

diabetes, pressure relief and training for awareness of pressure relieving mattresses was planned.

Improvements had recently been made to the supervision and appraisal system with staff receiving supervisions individually or in a group. However these were on specific topics rather than also to assess their performance and developmental needs in line with the provider's supervision policy. A number of staff, particularly registered nurses, had not received any form of supervision within 2016.

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

People mostly spoke positively about the food provided at the home. One person told us, "The food is up to scratch." A relative told us, "The food is good." Relatives told us that when their family member had moved to the home, the chef introduced themselves and took note of the person's 'likes and dislikes.' However one person said that they thought the meals could be improved and, "Meat and two veg" was served too often.

The service employed a full time chef and assistant and had a four week rolling menu that was changed seasonally. People were given options of what they wanted to eat. For instance, at breakfast time we saw people choosing from cereal, toast or a cooked breakfast, with a hot drink and fruit juice. Drinks were encouraged throughout the day. There was only one choice for the main lunchtime meal although people and relatives said that an alternative could be made if the person did not like the option presented. In the evening, there was a good choice. We saw the chef talking with people about what they wanted to eat for their evening meal and accommodating wherever possible. In the evening we saw people eating a variety of options based on their preferences from scampi and potato wedges to soup and sandwiches.

Food looked tasty and appetising. We saw people enjoying the food they consumed which was home-made and included fresh produce. We saw the chef had baked buns and cakes for afternoon tea which they told us they did on a daily basis. We observed there was a pleasant and social atmosphere at mealtimes with staff providing appropriate support and re-assurance.

We saw people's nutritional needs were catered for, dieticians consulted and supplements prescribed where people were 'at risk' nutritionally. People had their nutritional intake monitored with regular weight checks where required and use of the Malnutrition Universal Screening tool (MUST). We saw those people that required special diets received food of their choice in a form that suited their needs.

Where people were at risk of malnutrition or dehydration, their food and fluid intake was monitored by the service. These were generally well completed although we identified that there was a lack of target fluid input and no evidence of tallying the fluids and reviewing against a set target. Staff were not consistently documenting the reasons people had not had meals, for example if they refused. We raised this with the deputy manager who agreed it needed to be addressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. We found the service had made appropriate DoLS referrals for four people who used the service. Two DoLS authorisations were in place with the other two applications awaiting assessment by the supervisory body. However, we did identify a lack of care plans developed for people with DoLS authorisations in place, detailing how staff were to provide care in the least restrictive way possible. One DoLS authorisation had a condition attached around reducing the use of medication. We saw this had in part been met, however the provider had not formally requested a review of the person's medication with the GP and Mental Health team as per the condition. There was no reference to the attached condition and how to meet it within the person's care records. Staff we spoke with were not aware of who had a DoLS in place and did not have a proper understanding of DoLS. Where DoLS had not been applied for, we were unclear of the decision making process detailing why these applications were not required, with a lack of assessment taking place of the restrictions placed on residents lacking capacity to determine whether further applications were appropriate.

We saw care was provided in the least restrictive way possible with people encouraged to use the outside areas and some people were encouraged to leave the premises on their own.

We saw staff gave people choices in regards to their daily lives. There was a culture of asking people what they wanted to do, eat or where they wanted to go within the home. People confirmed they felt able to express their choices around staff.

Where people lacked capacity to consent to their care and treatment, capacity assessments had not been completed and there was a lack of reference to people's consent, and understanding of their care plans within care records. We found a lack of evidence to indicate decisions made for people lacking capacity were made as part of a best interest process. For example where bed rails had been provided, there was no evidence of a best interest process involving people, their relatives and health professionals to determine whether bed rails were in their best interest.

Communication care plans did not contain adequate information on people's ability to retain, and understand information and how they should be supported in the decision making process.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Some people's care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions held of the healthcare professional completing the form.

We identified the environment could have been better adapted to assist people living with dementia. There was a lack of appropriate signage around the premises to assist and direct people. Many of the bedroom doors did not indicate that they were bedrooms or who lived within.

People and relatives we spoke with told us healthcare needs were met by the service and did not raise any concerns about this aspect of the service provision. People's healthcare needs were assessed by the service and appropriate plans of care put in place. Where people had specific health conditions we saw evidence that care plans were developed by staff. Care records showed people had access to a range of health professionals such as GP's, chiropodists and tissue viability nurses.

Requires Improvement

Is the service caring?

Our findings

All the people we spoke with told us they felt well cared for by staff, as did their relatives. One person told us, "Everything is good here. I get taken out on request, the staff are very caring and top class, I've nothing but praise for them." Another person told us, "It's the staff, they make the place. Nothing is too much trouble for them, they are special. It's a wonderful, wonderful place. They do all they can to help and are great in their support. I am happy to end my days here." Another person told us, "The staff are fine. Absolutely perfect." One relative told us, "[Relative] likes it a lot here; she is happy which is the main thing. I can't really fault the staff." Another relative told us, "I moved heaven and earth to get her here. The deputy is fantastic and lovely, the staff are very welcoming and the ratios are fine. It's a smaller home, a little tired, but nothing is too much trouble." Another relative told us, "They look after my [relative] very well and I'm here every day so I see what goes on."

We observed care and support. Staff spoke to people in a gentle and compassionate manner. We saw examples where people's dignity was maintained. For example one person was struggling with their meal and staff quickly intervened and provided them with plate guard which helped ensure they did not spill food on themselves. Staff assisted people in a warm and caring manner and the atmosphere within the home was relaxed and friendly. Staff used both verbal and non-verbal communication techniques to communicate with people in a kind and friendly manner.

However this was not universally so. We identified some instances where people's privacy and dignity was not always upheld. We observed one person had their blood sugars checked by the staff member administering the medicines whilst sitting in the conservatory lounge where other people were sitting. The nurse proceeded to roll the person's skirt up to their thigh, tap their skin and administer an injection. This was in contradiction to the provider's medicines policy which stated, 'Prior to administering the medicine(s) consider the resident's privacy and dignity will be properly protected. Escort the resident back to their room if necessary before administering the medicine(s).' Whilst walking around the service, we observed a member of staff entering a person's bedroom without knocking to talk to another member of staff who was delivering personal care to that person. Whilst walking around the service we saw a person's bedroom door propped open with a commode whilst the person was lying in bed and visible from the corridor

At lunchtime, we found a system was in place to serve those who had a "normal" diet before those who required a soft/blended diet. This meant that these people had to wait for up to half an hour whilst others were eating before the food was served. We concluded this meant mealtimes were not always organised in a fair and equitable way.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

During the inspection we identified a pleasant atmosphere within the home with staff having the time to spend time chatting with people, and providing companionship as well as completing routine care and support tasks. This extended to the nursing staff and management who also spent time providing

companionship to people.

People's independence was prompted wherever possible. For example one person was supported to prepare some of their own meals and encouraged to access the community independently.

Staff appeared kind and caring and knew people's likes, dislikes and care needs. This was due to a stable staff team. It was clear there was good bond between people who worked at the service and relatives. Staff we spoke with were able to tell us about people who they supported.

We saw staff respected people's wishes and choices, for instance when they got up in the morning, if they wanted a bath or shower, if they wanted to come to the communal areas or stay in their rooms. One person told us, "They don't push if you don't want to go. It's up to me if I want to go down." Whilst the registered manager and deputy manager did not always document people's views, wishes and opinions in a formal way, it was clear they valued people's comments and views.

Where people were approaching the end of their life, the service liaised with external health professionals to ensure appropriate care was provided, for example in the provision of anticipatory drugs. End of life care plans were in place to instruct staff on how to provide appropriate care. However we found there was often very little information recorded on whether the person's wishes had been discussed with them.

Requires Improvement

Is the service responsive?

Our findings

All the people with whom we spoke expressed a high level of satisfaction with the care received. Relatives supported this and praised the work and support of staff. People and relatives spoke positively about the care and support provided and stated that it met people's individual needs and preferences. One person told us, "Staff have really helped me to recover." However one relative told us that there was sometimes a lack of detail in terms of changing/cleaning bedding and ensuring their relative was consistently bathed. They said, "You really shouldn't have to ask about changing the sheets or bathing but they are very good and do respond when you raise issues or concerns."

People's needs were assessed prior to admission and appropriate care plans developed. The deputy manager demonstrated to us that a number of improvements had been made to care plan documentation over the last few months which included ensuring a full range of care plans were put in place and improved risk assessment documentation. We found care plans were largely appropriate and contained information for staff to provide appropriate care. However we identified further personalised details were required in some cases. For example, the settings for people's air mattresses was not explicitly identified within pressure area care plans or the type and size of slings to be used in manual handling tasks. We saw evidence staff assessed whether people had religious beliefs or cultural needs and arrangements were in place to help those needs being met.

Regular care plan reviews took place, however care plan reviews did not contain any evidence of involvement of people or their relatives as part of the review and evaluation of care and support.

People looked clean and well cared for, indicating their personal care needs were being met by the service. Nobody at the home had any pressure sores at the time of the inspection. We saw evidence that a range of equipment was in place to support good skin care. Where people required regular pressure relief we saw documentation was in place which provided evidence this was done at the required frequencies.

People provided mixed feedback about the quality of the activities. Some people told us they went out on their own and staff encouraged this. One person told us, "There is sometimes a quiz or discussion," and another person told us, "There are not a lot of trips, we don't get out much." The activity co-ordinator had recently introduced a four week programme of activities with support from the deputy manager. Activities included balloon tennis, sing-songs, dominoes, gardening and arts and crafts. The deputy manager told us they were intending to introduce an activities board so people could see what activities were taking place on a daily and weekly basis. The activity co-ordinator documented on a daily basis what activities people had enjoyed participating in.

All staff groups including care staff and management engaged people in social interaction to help meet their social needs. People were encouraged to maintain links with the local community. One person told us they were taken out by the deputy manager into the local community to stay in touch with life outside the home.

People told us that the registered manager and deputy listened to them and acted on any complaints and concerns. One relative told us, "When I raise things, they respond positively." The service had a complaints policy in place, although there had not been a formal complaint since 2013. This had been documented with actions seen to have been taken. People we spoke with said they had no complaints about the service and demonstrated a high level of satisfaction with the service. We saw evidence of compliments received in the form of letters, cards and emails. These included comments such as, "[Person] was getting the best care he could," and, "Very professional and caring manner."

Inadequate

Is the service well-led?

Our findings

The provider had failed to submit all required statutory notifications to the Care Quality Commission. We had not been notified of the two DoLS authorisations in place. In addition, a serious injury had occurred in March 2016 which the provider had failed to report to the Commission. It is vital that we are informed of these notifications so we can monitor events which occur within the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Staff told us they were happy in their role, that they had no concerns over the way the service was run and that morale was good.

People and their relatives were aware of the management team and knew them by name. They all said they had regular contact with the management team who were helpful and dealt with any queries or concerns raised. Through speaking with people, relatives, staff and observing care evidence suggested the management team were very 'hands on' , spending a great deal of time with people checking they were okay and dealing with matters in an informal manner. It was clear there was a culture of 'residents first'. We observed a positive atmosphere within the home with staff and people getting on well. However we did identify some working practices were rather institutionalised rather than based on person centred approaches such as the way mealtimes were organised with those requiring a blended diet receiving their food significantly later than everyone else.

We were also concerned about the lack of mechanisms in place to keep up-to-date with the latest best practice and legislative requirements. For example, there was a lack of environmental adaptions to assist people living with dementia and a lack of regard for Mental Capacity Act guidance in the care planning process. The registered manager was unaware that there was a requirement to report to the Commission where people had a DoLS authorisation in place, and the home was not up-to-date with latest best practice guidance on hydration and target fluid inputs.

Although a number of improvements had been made over the last few months such as to risk assessment documentation and some aspects of training, these had been led by local authority and clinical commissioning group involvement rather than the service pro-actively identifying and rectifying service shortfalls.

We concluded the "hands on" approach of the management team was to the detriment of having robust quality systems, clear policies and documentation in place. Systems to assess, monitor and improve the service were not sufficiently robust. During the inspection we identified six breaches of regulation. If a robust quality assurance system had been in place these issues would have been identified and rectified by the service prior to our inspection.

There was a lack of clear policies in place in some areas, for example around training and development. Staff had access to a large amount of training, some of which had clearly been given priority such as

safeguarding and manual handling. However there was no policy specifying which training was mandatory for each role and which training was optional. Staff competency was not assessed and monitored to identify skill gaps and used as basis to inform training needs. For example we identified some poor moving and handling practice, and staff did not have a good understanding of Deprivation of Liberty Safeguards (DoLS). These uses had not been identified as a training need and addressed by the provider.

Some audits were undertaken such as care plan audits. We saw evidence these had been successful in identifying some issues and improving the quality of care records. However, these were not always sufficiently robust. For example, they had failed to identify that best interest decisions were not always documented where people lacked capacity or that two people did not have the risks associated with bed rails assessed.

Where people's food and fluid intake was being monitored, there was no regular oversight of this to determine whether people had consumed enough food or fluids.

Audits had taken place in subjects such as health and safety, mattresses and an overall home audit which looked at a range of quality areas. Although these were due to be completed monthly, the June 2016 audits had not been completed. During the inspection, we identified that one air mattress was on the incorrect setting, yet the monthly mattress audit which could have identified this had not been completed since May 2016.

We found the overall home audit was not sufficiently robust; it contained a lack of findings and actions. We reviewed the 2016 audits which consisted of mostly ticks stating things were up to standard and a lack of actions for any of these audits within 2016. For example, recent audits had been ticked to state all water temperatures were below 43C. However water temperatures were not measured by staff and we also identified a number of outlets where water was not sufficiently warm. These areas should have been identified and rectified by the audit.

There was a lack of infection control and hand hygiene audits carried out. We identified that some chairs in the dining room would benefit from a clean and saw an unsuitable pressure cushion which should have been identified through an audit of this kind.

Medicine audits were not sufficiently robust. The registered manager told us that staff carried out a medicines stock check on a weekly basis. However they were unable to produce any documentation to demonstrate this was the case and when we checked medicine stocks we could not reconcile medicine stock balances. The monthly medicines audit carried out was not sufficiently robust as it had not identified issues we identified during the inspection.

Incidents and accidents were logged by the service. We reviewed accident forms and did not identify any concerning trends with regards to falls or any other incident type. However accident forms did not contain an explanation of the preventative measures put in place to keep people safe. For example, one incident had occurred where a person's leg had become trapped in a bedrail resulting in minor bruising. Although the staff we spoke with were able to explain the measures taken to keep this person safe, these actions were not clearly recorded within the care plan or the accident form. This meant there was a risk that all staff would not be aware of the new plan of care for this person.

Although the registered manager and deputy manager were very hands on and sought people's feedback on an informal basis, there was a lack of formal mechanisms for people feedback on the service. Periodic resident meetings were held however no satisfaction surveys had been done in recent years to confidentially

ask people about their thoughts on various aspects of the service. Care plans were reviewed monthly but contained a lack of information on people's views in relation to their care and support.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw plans were in place to improve the governance systems within the home for example through the introduction of a provider audit where the provider audited aspects of the home on a monthly basis. However this was not in place at the time of our inspection.

Staff meetings were held on a periodic basis. We reviewed the minutes of these which showed quality issues were discussed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1) People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent (3) The service was not acting within the legal framework of the Mental Capacity Act (MCA)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (2a) Staff had not always received timely training, supervision or appraisal.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures Treatment of disease, disorder or injury	(1) (2a) ,(2b), (2g) Medicines were not managed in a safe way. Risks to people's health and safety were not always assessed and mitigated.

The enforcement action we took:

We issued a warning notice to the provider and registered manager requesting them to become compliant with the regulation by 31 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	(1) (2a) (2b)
Treatment of disease, disorder or injury	Systems to assess, monitor and improve the service were not sufficiently robust. Systems and processes to learn from incidents and accidents were not sufficiently robust. There was a lack of systems in place to seek and act on feedback from people who used the service.

The enforcement action we took:

We issued a warning notice to the provider and registered manager requesting them to become compliant with the regulation by 1 September 2016.