Lifeline Nursing Services Limited

St John's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected St John's Nursing Home on 27 September 2016. This was an unannounced inspection. The service provides care and support for up to 37 people. When we undertook our inspection there were 35 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

There was a registered manager in post. 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.

We found three breaches in relation to the management of medicines, the Mental Capacity Act and the requirement to report incidents to CQC. You can see what action we have asked the provider to take at the end of main report.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS authorisations are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there were six people subject to such an authorisation. The provider had failed to ensure staff had been trained in the implementation of the Mental Capacity Act 2005 and therefore correct assessments had not always been completed.

We found that there were times of day when there was insufficient staff to meet the needs of people using the service. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, but care was not planned and delivered in a consistent way through the use of each care plan. People and relatives were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was not clear. Risks associated with people's care needs were assessed, but plans were not always put in place to minimise risk in order to keep people safe.

People were treated with kindness and respect. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence.

Staff had taken care in finding out what people wanted from their lives and had supported them in their

choices. They had used family and friends as guides to obtain information.

There was poor storage and administration of medicines. Staff had not kept accurate protocols for the use of some medicines to ensure people could be given them safely. Actions from medicine audits had not been signed to say they had been completed.

People had a choice of meals, snacks and drinks. Meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. The meal time was chaotic and not organised, which meant people sometimes were disrupted whilst consuming their meal.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home. Quality checks had been completed to ensure services met people's requirements, but actions had not been followed through to completion. The provider had failed to inform CQC of accidents and incidents which had occurred so we could make a judgement that appropriate action had taken place.

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.

Checks were not made to ensure the home was a clean place to live.

The registered manager had not consistently ensured sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse. However, they were not aware of an investigative processes outside of the home and how they could contribute to that process.

Medicines were not stored and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not understood by staff and people's legal rights were not always protected.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time. However, records did not always indicate what activities people took part in.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance. However, these were sometimes not dated and actions not signed off.

The provider had failed to inform CQC when accident and incidents had occurred so we could make a judgement of whether suitable action had been taken.

People's opinions were sought on the services provided and relatives felt their opinions were valued when asked.

St John's 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 27 September 2016 and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke to health and social care professionals before the site visit.

During our inspection, we spoke with two people who lived at the service, four relatives, four members of the care staff, two trained nurse, a housekeeper, a cook, the deputy manager and the registered manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings, accident and incident records and audit reports the registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

Although staff had received medicines training, and this was updated annually, we saw that there was poor monitoring of medicines which placed people at risk of not receiving their medicines as prescribed. Staff were observed during the morning and at lunchtime administering medicines. The staff member checked the medicine administration record (MAR) and stayed with each person until they had taken their medicines. However, they left the trolley unlocked on three occasions when they were administering medicines. Although they initially left a member of the care staff beside the trolley on two occasions the carer was called to do other tasks, such as observing people to ensure they were safe and could not always see the trolley.

Medicines were stored in a locked room. The medicine cupboards and trolley were locked but the refrigerator used to store medicines was unlocked with the key in the lock. Staff did not tell us of any discrepancies of medicines missing from the refrigerator or whether they had checked the required medicines were there. This meant other staff could have access to the medicines in the refrigerator. A stock check of medicines was completed daily. Some ointments and creams were labelled when open with the date they were opened, but most liquid medicines were not labelled. This is important to ensure they are used within the timescale required.

Records about people's medicines were inaccurately completed. The front sheet gave details on whether a person was allergic to anything but did not record how people liked to take their medicines. This included when a GP had authorised a person's medicine to be hidden in a substance to ensure they took their medicine. This action was to ensure people took their medicines as they were beneficial to their health. There was also no record of consultation with the pharmacist about covert administration, which means hiding or disguising medicines for that person, however, staff told us they had consulted with the pharmacist.

Where medicines were prescribed to be given only as required (PRN) not all protocols were in place to provide the information required about the medicines and the circumstances in which they should be given. Protocols were not in place for two people who were receiving sedative medicines to reduce their agitated behaviour in addition to other medicines.

Processes were in place for the ordering and supply of medicines. However, staff told us they arrived only a day or two prior to the commencement of a new cycle of administration. This gave staff very little time to correct any discrepancies. We were told the pharmacy supplier did flag issues to GPs in a timely manner. Medicines audits we saw were completed by staff at the home on a monthly basis but did not identify the issues raised by us to the registered manager. The local pharmacy supplier had also completed an audit in April 2016. This had identified issues including labelling liquid medicines with date if opened. However, we did not see an action plan to address the issues identified. We did see a general action plan which included two actions to improve medicines management. Reference material was available in the storage area.

This was a breach of Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) Regulation

2014.

People and relatives told us they had no concerns about their own or their relatives' safety. One person said, "I've not had falls or accidents." A relative told us, "I'm not worried at all about [named relative] being safe." Another relative said, "I don't' worry when I'm away. I know [named relative] is safe here."

The records showed 69% of staff had received training in how to maintain the safety of people. Staff were able to explain what constituted abuse and how to report incidents should they occur to the registered manager and deputy manager. However, they were not aware of the role of the local authority safeguarding team and how investigations were carried out. Staff were unaware of how their input could be valuable to an investigation and how lessons could be learnt from them ensured people could be safe living in the home. There was no further training planned on this topic.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded.

Individual risk assessments had been completed to assess people's risk of falls, nutritional risk and risk of developing pressure ulcers. However, the documentation stated the risk assessments should be reviewed monthly, but the frequency of reviews was variable. There were gaps of three months between some reviews. When bed rails were being used to prevent a person falling out of bed, a risk assessment had been completed to ensure they could be used safely. The frequency of reviews was irregular. We saw that when bed rails were in use most had padding in place to prevent the person from obtaining injuries. However, on one occasion we heard a person shouting for assistance and the bed rails had no protection. The person was sitting with their legs over the bed rails. We brought this to the attention of staff who responded immediately and made the person safe.

We did see a care plan which had a risk assessment in place after a person who frequently fell. This provided details for staff on actions to take to prevent falls such as ensuring the person wore well-fitting footwear.

Pressure relieving mattresses were in place for people at high risk of developing pressure ulcers. They were functioning correctly. However, there were no records to show they were being checked and cleaned on a regular basis. This could put people at risk if a mattress failed or had not been regularly cleaned and people could be at risk of developing an infection. Hoists were available and hoist slings were allocated for individual use. We observed staff using a hoist to transfer a person. They did this safely and talked with the person during the process to provide reassurance. However, there were no records in place to show when these had last been cleaned, which could be an infection risk to people.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would not remember where the exit doors were in the building. These had been reviewed in September 2016. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document. This had been revised in August 2016.

We were invited into 10 people's bedrooms to see how they had been decorated. In seven of the bedrooms we did not see a call bell to enable people to summon assistance. Staff told us that people in those rooms did not have the capacity to know how to use a call bell, but when they were in their rooms they would be checked regularly. This was not consistently recorded within the care plans. Staff had not taken into consideration when writing the care plans of environmental risks for some people, especially those with a history of falls. We saw some trailing wires in a room and furniture which would be in people's way to access

their bed. When we pointed this out to staff they moved the items.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. There were also signs on the other doors indicating what each room was used for, for example, a sitting room or toilet. The signs were in words and pictures. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

We identified a number of areas where a comprehensive approach to cleaning had not been undertaken. For example, we saw the inside of a toilet seat was soiled in a bathroom, we found cobwebs in an en-suite toilet and the radiators were soiled with a brown substance and were dusty. In a designated area for cleaning and storage we saw commodes and urine bottles which were not clean and there was debris and dust on the floor used to store hoists and other equipment. This could cause an infection risk to people if they were to use unclean items. The monthly infection control audit had not identified any cleanliness issues and neither did the infection control audit for July 2016. A member of staff told us they been attending a local infection control forum and had found this useful. They said their role was to pass on good practice which included asking other staff to complete a hand hygiene competency assessment.

People and relatives told us their needs were being met, but did not comment on staffing levels. Staff told us that there were generally sufficient staff on duty to meet people's needs. Staff told us that lunchtimes and mornings were difficult if there were staff shortages as those were the times people needed the most assistance to wash, dress and have their main meal of the day. One staff member said, "We use a lot of agency." They explained this was difficult as agency staff did not know the people they were expected to look after so this took longer to explain to them. Staff also told us that the use of agency staff could upset some people. Names of agency staff were recorded on the staff rota. Staff told us that if there were short term staff shortages that the deputy manager would assist with the personal care and treatment of people who needed it.

The registered manager's report which was sent to the head office of the management company did not describe how staffing levels had been calculated to ensure sufficient staff were on duty to meet people's needs. We observed that staff had to continually walk around the corridors to ensure people were safe as many areas of the home could not be seen from a central area. Staff told us this increased their anxiety about the risks to people as several people were at risk of falls and had behaviour which could be challenging to others. There were risks associated with not having sufficient staff on duty to meet people's needs and the layout of the building increased this risk as staff could not see people who were residing in large parts of the building.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location, however there were photocopies of the Disclosure and Barring Service records in the staff files. The registered manager was unaware of this and they were destroyed as those records cannot be photocopied. The files contained details of their initial interview and the job offered to them. There were currently staff vacancies for registered nurses and care staff and advertisements placed for those posts in the local community.

Requires Improvement

Is the service effective?

Our findings

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had not followed the requirement in the DoLS. A DoLS checklist was in place, but this was not based on current guidance. Some of the checklists indicated a person did not need a DoLS authorisation, however, other information in the person's care plan suggested an authorisation was required. Six applications had been submitted to the local authority and the provider was waiting for the supervisory bodies decision.

The entrance to the home was through a locked door. Senior staff had the key to this door with them at all times and where aware they needed to open this first in the event of a fire. Staff told us this ensured people's safety of others not gaining entry that did not have business in the home. We did see two people asking to go outside, but they were redirected to other parts of the building or the enclosed garden. Entrance to an enclosed garden was through a locked door, which staff had to unlock if people wanted to use that area. Staff told us people could walk safely in the first part of the enclosed garden, but most required an escort to use the larger part of the garden. Assessments were in people's care plans of their capability of going out of the building without an escort. All the bathroom and toilet doors were locked so people had to ask staff to open them if they wanted to use them. A temperature control was fitted o the hot taps, but staff were concerned people may flood the area and make it unsafe to walk in those areas. Staff told us the majority of people were not capable of identifying hot and cold taps so were at risk of scalding themselves. Assessments of people's capability on this risk were not in their care plans.

We observed one bedroom that had a combination lock on the door. A relative confirmed this had been at their request and was only used when the person was out of the room. Staff told us the person was not capable of using the lock, but a risk assessment was not in place to state why this type of lock was in use. Unless the relative had LPOA they cannot request restrictions to be put in place. When we and the relative asked for the room to be unlocked, staff had difficulty opening it as the numbers were so small on the dial mistakes occurred when trying to open the door. This could put the person at risk of the door being closed with them inside and staff could not get to see them easily.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. However, these were not in all the care plans of people who

required a mental capacity assessment. Some had a title such as for care and treatment, but it was unclear why other assessments had been completed. They did not show the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. In some care plans it showed when best interest meetings had been held, but this was inconsistent and there was no other evidence to show that staff had acted in the person' best interests. Where people had a relative who had lasting power of attorney (LPOA) over their affairs this was recorded, but a copy of the LPOA could not be found. This could result in confusion about who could make decisions on behalf of the person.

The provider had not properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

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

People we spoke with and relatives told us they thought most staff were able to meet their or their family's needs. However, a relative told us they felt the less experienced staff had not received sufficient training to meet the needs of those with more complex needs.

None of the staff we spoke with had been newly recruited. However, they told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The registered manager told us that they were now looking at ways to implement the Care Certificate for all staff. This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling and fire safety. They told us training was always on offer and it helped them understand people's needs better. Each topic of training was entered on a record showing statistics for each topic. For example, 68% of staff had completed training on diet and nutrition, 77% had completed health and safety training. Staff had also completed training in particular topics such as dementia awareness, end of life care and challenging behaviour. No clinical update training had been provided in the last year and staff told us they accessed this training themselves. There had been no training in wound management, despite some people needing wounds dressed in each week. This is an area which is constantly changing and requires frequent updates. However, staff told us they would ask community nurses for help if they were unsure of recent good practice recommendations. This was not documented. There was a system in place to ensure gaps in staff training were actioned and this was also reviewed at appraisal sessions with staff.

The registered nurses were being supported to maintain their registration with the Nursing and Midwifery Council (NMC) through discussions and peer support sessions. A record was kept of when each nurse required to revalidate their registration with the NMC. They told us they were supporting each other when their revalidation dates were due with the NMC.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the registered manager at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a supervision planner on display showing when the next formal sessions were due. All staff had received at least two formal supervisions since January 2016.

All the relatives we spoke with said they were happy with the meals provided. One relative said, "Diet wise

the food is good and [named relative] still has a good appetite." Another relative told us, "[Named relative] clears her plate." However, one relative told us that lunchtimes were chaotic and they felt extra staff would help at this time." One person told us they had enjoyed their lunchtime meal.

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. We saw in one person's care plan that they had previously lost 4kg of weight over a month. It had been identified the person should be offered high calorie snacks and supplements, which was recorded. However, the person had not been weighed in the last month so staff could not gauge whether the extra supplements were working. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes and the type of diet required. This ensured staff were aware of what people liked to eat and drink to maintain a healthy diet.

Menus were on display in the dining rooms and within the kitchen area, but this was only in word format. This meant people who could not read English or required a picture format to communicate would not understand what was on offer each day. There was a second option on the menu, but we did not see this offered to people.

We observed the lunchtime meal in two dining rooms. One was a small room where two people were taking their meal. One was in a chair they had been in all day. The other was sitting at the dining table. The main dining room was open plan to a sitting area. there were dining tables in the room, but only one person was sitting at the table, everyone else were in chairs they had been in all morning. This was a chaotic period and lacked organisation. There were not enough staff in the sitting room area to provide the assistance and support people required. Where people needed assistance a member of staff sat with each person, but the staff members were constantly interrupted when others were calling for assistance or to intervene to maintain people's safety. On two occasions inspectors had to intervene as a person was being disruptive to other people eating, as staff were busy and had not seen the potential risk to others. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required. People were offered hot and cold drinks throughout the day.

We observed staff attending to the needs of people throughout the day. We heard staff speaking with relatives about hospital appointments and home visits. Staff told us they only approached relatives to give or obtain information if the person had given permission. A relative told us how quickly the staff had responded when their family member became ill. They said, "I fetched the manager and they got [named relative] into hospital straight away." This was recorded in the care plans. This was to ensure those who looked after the interests of their family members knew what arrangements had been made. Referrals to other health care professionals was through the GP practice. Staff told us this was sometimes a lengthy process and responses did not occur as quickly as they liked. For example, when a person required a referral due to swallowing difficulties they had to wait several weeks before an appointment was made for them. This could have caused the person to become distressed or choke when eating. Staff had recorded when people had required an optician or dentist and the outcome of those visits.

Good

Is the service caring?

Our findings

People and relatives told us they liked the staff and felt well cared for by them. One person said, "They are all very nice." Another person said, "The girls help me to get dressed." One relative said, "They always talk to [named relative]." Another relative told the staff were caring, however said, "They do seem to be run ragged at times."

The people and relatives we spoke with gave us conflicting views of how they were supported to make choices and their preferences were listened to. One person said, "I like to stay in my room for most of the day, which staff respect." A relative told us, "The only thing I've picked them up on was cutting [named relative] nails."

People were given choices throughout the day if they wanted to remain in their rooms or bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff. We observed one staff member sitting with their arm around a person giving them reassurance. One person was sitting in a quiet area watching a film. Staff asked the person if they wanted a different choice, but the person declined. The person attempted to sing some of the songs from the film, which staff joined in with to encourage them.

All the staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone was becoming anxious staff knelt down beside their chair and talked calmly to the person. The person was then calm and watched what other people were doing. We also observed people who wanted to mobilise independently, but slowly, being allowed to do so. Staff constantly walked around the building ensuring people were walking safely and there were no obstacles in their way.

Some people either through choice or because they were ill choose to remain in bed. We observed staff attending to people's needs. They politely asked what they required before fulfilling the person's wishes. We saw staff returning to people's rooms throughout the day to ensure they had everything they needed. We observed staff asking people if they were comfortable or would like to move position. Some people could not move very easily so staff returned frequently to them to help them change their position in bed. Staff then recorded on a chart the actions they had completed. When people required to be moved with the aid of a hoist staff ensured the person was covered before moving them to protect their dignity.

Throughout our visit we saw that staff in the home were able to verbally communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. However, when people shouted out requests across a room the response from staff was variable. Some staff went directly to the person, whilst others gave a response across a room. Sometimes people heard the response from staff, but on other occasions the request was

repeated. Staff then approached the person with an answer.

We observed staff helping someone whose behaviour was challenging to others. They ensured the staff member who used the call bell system was not on their own and gave reassurance to the person concerned. Other people in the area were politely asked to move away until the situation was calmer. People did this readily. A relative said to us, "Some people's behaviour is difficult to manage, but staff are always calm."

People told us they could have visitors whenever they wished and this was confirmed by relatives. We saw signatures in the visitors' book of when visitors had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. Relatives told us they were offered refreshment when visiting. This was recorded in the care plans. One relative told us, "I can come whenever I please." This ensured people could still have contact with their own families and they in turn had information about their family member. People and relatives told us staff would telephone their family members when they wanted to speak with them and people could do this privately in an office.

All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Staff greeted people with their first names if this was their wish. Staff engaged with people about the person's day, asking a person's well-being or engaging in lengthier conversations.

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission before commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the time of the inspection.

Requires Improvement

Is the service responsive?

Our findings

The people and relatives we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. One relative said, "Anything to do with [named relative] they always let me know." All the relatives we spoke with told us they were happy with the home.

Relatives told us staff had talked with them about their family members specific needs, once staff had checked the relative had authority to speak on a person's behalf." This was in reviews about their care. They told us they were aware staff kept notes about their family member and they were involved in the care plan process. One relative said, "[Named relative] has a named worker." A named worker is a member of staff who looks after the interests of a set number of people and to build a rapport with them. Another relative told us of discussions they had with the funding authority for their family member's care and how staff had arranged the meeting.

The care plans gave basic information about each person, but little information about people's preferences. Such as a person's communication care plan did not contain any information about the person's hearing. A continence care plan stated how regularly a person was to be checked throughout the day for soiled or wet incontinence pads, but there was no information about the frequency of the checks or what type of pad was to be used. There was no toileting regime included in the care plan or a care plan on skin integrity.

Some people's care plans had been written over a year ago and the monthly reviews indicated there had been no changes when some people's abilities had deteriorated. For example, a person had a breathing assessment and care plan which stated they should be sat up when possible. The person stayed in bed and wasn't up during our inspection. However, we saw that a GP had been called out three times in the previous three months due to shortness of breath and wheeziness. This had not been mentioned in the care plan. Some care plans which had been recently re-written contained a better level of detail. The registered manager showed us a plan of when each care plan would be rewritten and this was being monitored by the area manager.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use. Staff told us this was used as a reminder of what actions had taken place. We observed the lunchtime handover. This was unhurried and staff were given time to ask questions. Details included the well-being of each person, what medicines required to be ordered and any wound dressings still to be refreshed. However, this took place in the staff room and there was some distraction from people eating their lunch and washing dishes. The registered manager told us this was under review and they were looking at another place to hold the handover meetings. Staff told us they had made suggestions about a more appropriate setting.

People and relatives told us that staff knew them well and how each person's beliefs could influence their decisions to receive care and support. Staff knew how to meet people's preferences with suggestions for additional ideas and support. This means people had a sense of wellbeing and quality of life. Information

leaflets were on display about a variety of topics such as; local health care services and some leaflets on specific illnesses.

We were informed that an activities co-ordinator was employed, but they were not on duty the day of the inspection, but staff attempted some activities with people throughout the day such as a card game, a quiz and providing reading material. We observed a staff member in the morning sitting reading with someone. They kept separate records from the care plans. The activities records stated people's general interests, past employment and preferred social activities. A lot of the information was generalised in the activities records and did not always state the activities people had participated in. They also stated people's personal goals. One person's goal was to fold socks, clothing and clean the brass, but staff had not recorded if those activities had taken place. Some people were taking enjoyment from doll and pet therapy throughout the day and staff tried to encourage them to talk about their children and pets they had owned. specialist people brought pets in for people to stroke and learn about the pets care.

People and relatives are actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each relative knew how to make a complaint, but the process was in written English only. This meant that some people who could not read this would not understand how to make a complaint. No-one we spoke with had made a formal complaint since their admission. The complaints log gave details of how complaints should be recorded and actioned. However, there had not been any formal complaints for some years.

Requires Improvement

Is the service well-led?

Our findings

There was no process in place for reviewing accidents, incidents and safeguarding concerns. The records of accident and incidents were kept in a box, but there was no order to the filing system. The registered manager was unaware that the local authority commissioners required accidents and incidents to be notified to their safeguarding team. This had not taken place. Staff gave us mixed views about accident and incident feedback for lessons learnt. One staff member said, "[Named staff member] doesn't do feedback." Another staff member told us the manager fed back to staff members individually. There was no record of any lessons learnt feedback being given to staff.

We saw that in the accident and incidents records there were several which were required to be notified to CQC. These had not been reported to CQC which they are required to do by law. These included incidents where accidents had occurred, which had resulted in admissions to hospital. Also where there had been altercations between people, which in some cases had resulted in injury. These had not been reported to CQC. The registered manager was not aware of the full extent of notifications to be sent to CQC.

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

There was a registered manager in post. People told us they could express their views to the registered manager and deputy manager and felt their opinions were valued in the running of the home. One relative said, "I have no problem speaking with the manager if I have a problem." Another relative said, "If I'm unsure about anything I go and ask and they come straight away." This was when we asked the response time of the management team to concerns raised.

Questionnaires had been sent to people on topics such as services provided. The registered manager told us that 32 were sent out in August 2016, but only two were returned. It was felt by the registered manager a fair analysis could not be made with such few results. Relatives told us they had the opportunity to attend group meetings with the registered manager and other staff, which took place throughout the year. They said they were advertised in the main reception area. We saw the minutes of the meeting, which we were informed had been the last one, but it had not been dated. A number of topics were discussed; such as the laundry, activities and the current management arrangements. People had been given opportunity at the end of the meeting to ask questions and the responses recorded.

Staff gave us mixed views about how they received information, but said they felt their views were valued. When speaking about one member of senior staff, a staff member said, "[Named staff member] is a diamond." Another staff member said, "You feel more comfortable speaking to some people than others." Staff told us there was good peer support between staff. One staff member said, "I love working here. It feels like coming to work with friends."

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meetings for May 2016 and June 2016. The meetings had a variety of topics which staff had discussed, such as meal times and medication

issues. This ensured staff were kept up to date with new polices. Staff told us this had been a difficult year as the provider had gone into administration, but felt the management company were keeping them informed as events occurred. We saw an action plan the management company had put in place. This gave dates of when actions were due to be completed and signed when this happened, such as care plan reviews. The management team were also keeping CQC informed of their decision making processes.

There was evidence to show the registered manager had completed audits to test the quality of the service. These included kitchen audit, maintenance audit and room inspection audits for safety purposes. Where actions were required these had been detailed within the reports. However, the actions did not state when they had been completed. Some of the audit sheets were not dated so we could not see whether they had been completed in line with the company policy. The audits and other quality assurance systems did not identify the issues we raised in the breaches of Regulations 11 and 12.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet. This home is part of a small company so the registered manager had the opportunity of meeting with other home's managers, area staff and head office staff on a regular basis.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not informed CQC through the notification process of accidents and incidents which had occurred where harm had come to people.

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 Staff were unaware of how to implement the Mental Capacity Act 2005 and how to record decisions made on people's behalf who could not make informed decisions for themselves.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored safely and staff did not administer medicines using safe practices.