

Diginew Limited

Amber Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 3 and 10 May 2018. The first day was unannounced; the second day was announced to ensure the registered manager was available in the home.

Amber Lodge Nursing Home provides residential and nursing care to older people including people who are living with dementia. Amber Lodge Nursing Home is registered to provide care for up to 40 people. At the time of our inspection there were 38 people living at the home.

A registered manager was 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.

On this visit we found that there were breaches in providing person centred care, dignity, adequate infection control, medicines, safeguarding people from abuse and governance in that effective systems were not in place to assess and monitor the quality of care.

We found a number of infection control issues throughout the home. Documents relating to people's health and safety were not managed or reviewed. Notifications which the provider is duty bound to send us had been forwarded.

Staff understood the need to protect people from harm and knew what action they should take if they had any concerns. However, the provider had failed to report some safeguarding issues. Staff understood their role in caring for people with limited or no capacity under the Mental Capacity Act 2005.

People were provided with a choice of meals that met their dietary needs, though some people's diet was restricted. The catering staff were aware of people's dietary requirements, and people's opinions were sought about the menu choices in order to meet their individual dietary needs and preferences. The communication about dietary changes did not always feed through to all staff.

There was little in the way of stimulation and activities were not planned well in advance and were not tailored to people's individual needs and capabilities. Some staff had had access to information and a good understanding of people's care needs. However, communication about care plan changes and inconsistency of staff reading updated care plans placed people at risk from inconsistent care. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

People who used the service and their relatives gave us mixed comments about the nurses and staff, and the care offered to their relations. Some people were involved in the review of their care plan, and when appropriate their relatives were included. Staff had access to people's care plans and most received regular updates about people's care needs. Care plans included changes to people's care and treatment and people

were offered and attended routine health checks.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

Staff were aware of the reporting procedure for faults and repairs and had access to the contact details of maintenance contractors to manage any emergency repairs. The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours if an equipment repair was necessary. However, the registered manager had failed to ensure electrical repairs were followed up.

The provider carried out some quality monitoring checks supported by the consultant and home's staff, though the checks performed by the registered manager were not regularly recorded. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service and their relatives by questionnaires but not face to face meetings.

We received feedback from the commissioners who funded people's care packages with regard to the care and services offered to people at Amber Lodge Nursing Home.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

People were placed at risk from acquired infections, through poor infection control procedures. Medicines were not administered or stored safely.

Staff were employed in sufficient numbers to protect people and understood their responsibility to report any observed or suspected abuse. However the provider failed to report alleged abuse.

Infection control risks to people were not well managed. Concerns about people's safety and lifestyle choices were discussed to ensure their views were supported.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Staff training, information and supervision was variable and did not meet people's needs consistently. People were offered a balanced diet and met their nutritional needs. Staffs knowledge of people's dietary needs was poor and the availability of drinks was variable.

People received health care services and staff understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care before it was provided.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

Staff did not protect peoples' privacy and dignity and people were not included when making choices about their care. However we saw staff were caring and kind and treated people individually.

Requires Improvement ●

Is the service responsive?

The service was not consistently responsive.

Requires Improvement ●

People's care records were not person centred or consistent with their care needs. Staff recorded people's preferences, likes and dislikes and how they wanted to spend their time, however activities were not person centred or provided on a regular basis

People were confident to raise concerns or make a formal complaint where necessary.

Is the service well-led?

The provider did not have an effective overview of the home or take action to protect people as needed. Effective systems were not in place to assess, monitor and improve the quality and consistency of information produced by staff.

There was a registered manager in post. People using the service, their relatives and staff had limited opportunities to share their views and influence the development of the service.

Inadequate ●

Amber Lodge 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 3 and 10 May 2018. The first day of the inspection was unannounced and was carried out by two inspectors and a nurse specialist adviser. Our specialist adviser's area of expertise was the care of older people and those living with dementia. The second day of the inspection was announced to ensure the registered manager was available and was carried out by two inspectors.

Before the inspection visit we looked at the information we held about Amber Lodge Nursing Home including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

The registered manager, consultant employed by the provider and a nurse assisted us on the inspection. We asked them to supply us with information that showed how they managed the service, and the improvements made regarding management checks and governance of the home following our last inspection visit. We also received information from them following this inspection visit. The consultant is a registered nurse and was employed to assist the provider in improving the quality of care and environment in the home.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with eight people and one relative to gain their experiences of living at, and visiting, Amber Lodge Nursing Home. We also spoke with the registered manager, consultant, two nurses, four care staff, two

housekeepers and the cook.

We looked at five people's care plans and records to see how they were cared for and supported. We looked at other records related to people's care such as risk assessments, medicine records and notes of day to day care provided to people. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Is the service safe?

Our findings

There were no adequate arrangements for keeping the service clean and ensure that people were protected from acquired infections. Though we spoke with people about the cleanliness of the home no one made any direct comments. However, one comment that was made through a questionnaire distributed to the people in the home, indicated, "The carpets in the lounge area could do with replacing or deep/steamed cleaned." We asked the registered manager about this and he said the carpets had been replaced. A staff member commented, "[The] cleaning is better; it used to be worse than this."

We looked at the environment to ensure it protected people from the risk of cross infection and cross contamination. In a first floor lounge there were a number of chairs in a very poor state of repair. Some of the seating was perforated and split exposing the padding below. These could not be adequately cleaned or disinfected and could place people in danger from cross contamination. There were offensive odours in some parts of the home and some of the equipment was dirty. For example, the rotunda and stand-aid were covered in a film of dust. The area behind one toilet was stained with faecal matter and urine stains, there was wood placed under toilet bowls to raise the toilet height. This had not been treated and allowed the potential for cross infection and cross contamination. Some foot operated bins had no liners inserted which again allowed the potential for cross infection. We saw hair brushes around the home, however staff could not identify whose they were as they were not named.

The provider had not produced cleaning schedules which meant there was no detailed instruction for staff to clean and disinfect areas of the environment which placed people at risk in the home. That could allow dirt and dust to accumulate in these areas which is a potential threat to people from cross infection or cross contamination. A member of staff told us, "There's no deep cleaning checklist to follow, we just use our initiative. No one comes to check what we've done."

We saw there had been an 'environment check' that had been completed by the registered manager. That highlighted some potential infection control risks, but did not include the wood placed under the toilet bowls, or the lack of detailed cleaning schedules.

We saw a skin cream stored in a bedroom which had no prescription label or name on the pot. That meant it could have been used for another person and allowed the potential for cross infection.

The home had two bathrooms and two walk in shower rooms. One of the baths and one of the shower rooms were not in use. The flooring needed replacing in the two shower rooms. Though the bath was usable, the registered manager said they were awaiting a replacement bath which would provide a better service to people who lived in the home.

The registered manager stated that staff had been trained in infection control and health and safety and that the provider had relevant policies and procedures to guide staff and the management. However, it was evident that training had not been put into practice and procedures were not followed and management did not carry out follow up checks. That meant people's health and safety had been put at risk.

This was a breach of Regulation 12 (2) h of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment related to the potential contamination and transfer of infections to people living in the home.

Not all medicines were stored or disposed of safely. The storage of some medicines was not well organised and some medicines stored in a fridge had been discontinued by the GP but not disposed of. That meant these could have been given to the person by mistake as they were no longer prescribed for the person. Some medicines need to be disposed of in such a way the staff rendered them unusable, and a record made by staff. Nursing staff could not explain how they disposed of these medicines or where this was recorded.

We observed how staff administered medicines to people, and saw staff encouraged them to take their medicines, and stayed with them to ensure they were taken. However, when we spoke with one of the nurses about an injection that was to be administered periodically they were confused how to check to see when it had last been administered. We asked the registered manager about staff competency checks. They told us these are performed by another (usually more) senior nurse or consultant and are used to ensure staff who administer medicine remained competent and safe to do so. The nurse stated they had a competency assessment recently but we were unable to evidence this on the day. We asked the registered manager about this but they could not explain why there was no evidence to back up the assessment. The registered manager said competence checks for nurses were completed every year or two. That meant best practice guidance was not being followed for the review and assessment of nurses competence in medicines management.

The provider could not demonstrate they had completed any audits on the medicines system to ensure it was operated safely. The registered manager told us they did audits but did not record the outcomes, and could not tell us if they had found any errors how the system was operated. That did not demonstrate a medicines system that was operated safely.

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

A member of staff said, "Abuse could be shouting at people, neglect or physical. If I saw anything, I would report it to the manager. If they didn't do anything I'd report it to the safeguarding or CQC."

However, we were informed of a concern regarding a person allegedly being abused. We referred this to the appropriate body to investigate the allegation. That meant that staff were aware of an abuse allegation, but had failed to report this on to any authority other than the management team in the home. We spoke with the registered manager who said he had not followed the incident up as the staff member had left the home. He said one member of staff was, "A bit bossy [when speaking with people] and they had not been disciplined for abuse."

One persons' relative told us they were regularly spoken with by staff regarding the care and safety of their relation. Care staff felt that people were cared for safely and were protected from harm. Care and nursing staff said they would report any concerns or suspicions of abuse to the registered manager or deputy. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

We found staff were not always employed in sufficient numbers to protect people from harm. One person said, "Staffing is a problem; never enough staff on and they don't always come quick enough." A second person said, "Not enough staff." A third person said, "Agency staff don't always know how to look

after me." We asked the registered manager about this. He said he would look into the comments and said agency staff are usually accompanied by a member of the permanent staff team.

On the first day of our inspection a care assistant was taken from the first floor to undertake activities. This left the first floor staff group with three, rather than four care staff. Staff provided mixed opinions on staffing numbers. One member of staff said, "Staffing is not great; we should have at least four carers but are usually short or use agency staff." A second said, "Staffing is good, we have four and four, that's one nurse and four carers on each shift." We looked at the staffing rota for the week and spoke with the registered manager who said there were two additional nurses and at times five care staff on each floor of the home, and agency staff was now at a minimum.

We saw staff responded to people's needs and requests promptly. However, staff told us they had concerns about the staffing numbers, especially at weekends. Some staff also told us that they felt there was short staffing at other times. We looked at the staffing rota, and day time care staffing varied from four to ten and evening numbers between four and seven. We confirmed these staff numbers were typical of the staff rota. We asked the registered manager why the staffing numbers were so variable and he said this was to take account of 'family friendly' hours and cover for sickness and annual leave. Family friendly hours assist staff with caring dependants retain employment.

Checks on the fire and evacuation system were completed regularly; records included weekly checks on fire doors and door closers. However, there was no record of which staff attended the fire practice, and no dates when these had taken place. That meant the management had no way of ensuring all staff had been trained in fire procedures and evacuation, which placed people in the home at risk of harm. Staff we spoke with were unsure when they had their last fire and evacuation training.

We saw that the moving and handling hoists and slings had been serviced regularly though some slings had needed to be replaced. There were other checks on the equipment in the home. Safety certificates proving they were serviced regularly were held in the office. However, on the first day of our inspection we discovered there was some work required to the electrical system to make it safe. However, on the first day of our inspection we discovered there was some work required to the electrical system to make it safe. We asked to see the safety certificate relating to five year electrical test certificate, which was produced on 20 September 2017. There were two faults that was classed as 'potentially dangerous'. Remedial action was required, however no remedial action had been taken by the date of our inspection 3 May 2018. The nominated individual was made aware of the test results but had not arranged for any remedial action which placed people at risk of harm and demonstrated a lack of oversight through good governance. This was then arranged by the registered manager. That did not demonstrate the provider ensured the safety of people in the home.

People told us that they felt safe and staff cared for them safely. One person told us, "I've been here a long time and the staff know how to look after me. I've got the call bell here and someone always pops in to check on me."

Staff we spoke with had an understanding of the different types of abuse people could be subjected to. One member of staff said, "Safeguarding could be neglect and racism. I would report it to the manager."

Staff told us they had received training on how people should be protected from abuse or harm. Staff were aware of their role and responsibilities in ensuring people were protected and what action they needed to take if they suspected abuse had occurred. Staff we spoke with were aware of whistle blowing and knew which authorities outside the service to report any concerns to if required. The provider had a safeguarding

policy and procedure in place that informed staff of the action to take if they suspected abuse.

When staff were asked if people were safe in the home one said, "Yes, people are safe, we're all trained and we make sure everywhere is clean, there's not obstructions and we make sure the main door is locked." The member of staff clarified this was to protect people from wandering from the building.

Staff demonstrated their awareness of people's individual needs, and the support they required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. People's care records included risk assessments, which were reviewed regularly and covered the activities related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. Care plans provided guidance for staff in respect of minimising risk. A relative told us they were involved in discussions and decisions about how risk was managed.

We looked at four staff files and the staff recruitment records and found that the relevant background checks had been completed before staff worked at the service. We saw that nurses' professional registration was checked regularly to ensure they were registered with the Nursing and Midwifery Council (NMC). These checks helped to ensure that only suitable staff worked at the home.

Changes that have been introduced by the management staff and outcomes from investigations were documented and any lessons learnt fed back to staff. We saw from the minutes of staff meetings where outcomes were explained and staff prompted to ensure their practice was changed accordingly. The registered manager said if any issue was more personalised they would be followed up at one to one meetings, to ensure confidentiality.

Is the service effective?

Our findings

A relative told us, "I've been involved in the assessment process. I know there is a care plan for [my relative]. [Staff] keep me informed of what's happened; changes in [their] health."

When we asked staff about the information they received when new people moved into the service, their responses were mixed. One staff member said, "[The consultant] gives us all the information we need about a new resident." However, another staff member said, "We don't always get told when someone new has moved in the handovers. Once, we all thought this person was a visitor. It was only when they asked what they were having for tea that we realised it was a resident not a visitor." This was an example of staff not always having the information they needed when a new person came to the service.

The registered manager explained how people's needs were assessed prior to their move into the home. People's needs and choices were assessed to provide the basis of a care plan which could then be developed throughout the person's stay to reflect any of their needs that had changed. The initial assessment covered areas such as levels of support and how staff were to meet people's cultural, physical and mental health needs.

People's views about staff's knowledge and skills were mixed. One person said, "Some staff could do with more training, when they handle me [when being re-positioned in bed]."

A staff member told us that the induction training was mostly done on-line and practical training included fire safety. A second staff member said, "I shadowed a carer until I felt confident [to support people]." A further staff member said, "No one has checked my practice in how I move people. I've had no supervision and no one has asked me how I am doing or if there is any other training I'd like to do." We asked the registered manager about this and they said care staff competence checks varied from person to person. For example, staff could be seen three times just for moving and handling people, for assisting with walking, hoisting, and moving people in bed. There was no record of what competence checks had been undertaken by the management team.

Another staff member said, "I don't feel I need to re-do my training. I know the residents and what help they need. Some staff are doing training in mental health, which I did a few years ago and I don't think anything has changed." This showed that some staff did not recognise the importance of regular training and awareness of the current best practice to meet people's needs effectively.

We asked the registered manager for the training matrix as we were unable to view it on the day of the inspection. We then asked for it to be sent at the same time we requested the staff supervision dates. Supervision is one way to develop consistent staff practice and ensure training is targeted to each member of staff. We did get supervision dates for 2018, but this did not show people had regular supervision sessions and we asked for the 2017 dates. We were not sent these, but we did note that in the staff meeting minutes staff were told they would receive supervision 'once or twice a year'. These sessions are not regular enough to ensure issues are dealt with promptly and staff work as a team and we could not be assured the provider

had a suitably qualified and competent staff group.

We saw staff provided regular drinks to people. However, drinks were not always available for people to help themselves. For example, in the first floor lounge we saw two different flavoured cordial bottles. The consultant told us that staff would bring a jug of water and clean glasses later that morning. However, we saw this was not the case. That meant people were unable to help themselves to additional drinks.

One person said, "The dietician told me that I needed fork mashed food. Some staff give me crushed food and others refuse to give me what I want to eat." We asked the registered manager who said some people's diet is restricted, for example someone on a fork mashed diet wouldn't be given chips.

People told us the meals were generally good. One person said, "The food is ok. I enjoy eating bacon." A second person told us that there was a choice of meals each day and alternatives were available should anyone wish for something different. We observed a staff member showed two plated meals to a person to enable them to choose when they wanted to eat. A relative told us the staff had sent out for a meal that met their relative's cultural needs.

Information about people's dietary needs was displayed on the notice board in one of the dining rooms. This showed that people's confidentiality was not maintained and was an institutional practice that met the needs of the staff rather than the people using the service. Communication about people's dietary requirements was poor; a carer who was assisting a person with a meal was stopped by the chef. The person's dietary needs had changed following an assessment by a dietician; the member of staff told us no information was given about this in the handover. We asked the registered manager who said he would remove the information and review the information at handovers.

Meals were presented well and portions sizes suited individual appetites. Some people used adapted cutlery so they were able to eat independently. We saw staff provided sensitive care and support to people during lunch; they encouraged people to eat and offered support where required and second helpings. We saw a person was offered the lasagne which was declined, and then the staff member offered a cheese sandwich which had been cut into small pieces, which the person did eat eventually with a lot of encouragement. The staff member said, "[Person's name] tends to refuse but we try to offer different things. We record what [they] have eaten and will tell the nurse."

When we observed people at lunch one person enquired why they could not have a desert spoon to eat their ice cream, the staff member explained that the dietician had provided guidance to help ensure they ate 'bite size pieces' when eating. This information was presented in caring way so that the person could understand.

People had access to healthcare services. One person said, "The surgery is next door, so if you need to see a GP [staff] will request a visit." Another person said, "I've asked the staff to ask the doctor for a meeting to explain what my options are [to manage their medical condition]. A second person said, "I've asked the staff to ask the doctor for a meeting to explain what my options are [to manage their medical condition].

A staff member said, "I would know when someone isn't feeling well and would let the nurse know. [Named nurse] is good and she will check the person and call the doctor if she needs to." Care workers told us they relied on the nurses to inform them about changes to people's health in the handover meetings. This helped to ensure they continued to provide appropriate support.

We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician.

People had been encouraged to personalise their bedrooms; people had brought in personal items from their own homes when they had moved in which had helped them in feeling settled. The adaptations and design enabled people to move around the home. Corridors were mostly well lit and pictures hung on the walls created a homely feel. The consultant told us the lighting was due to be replaced on the ground floor corridor to improve the levels of light.

The garden space was accessible for people to use in good weather. There was a painted mural on one wall and artificial grass covered the concrete flooring. Seating was available for people to use on warmer days. There was a shed in this area that was used by the staff as an outside smoking area. The door was open, and people could walk in which might put them at risk of coming into contact with smoking materials. The registered manager said, this was due to be re-decorated and a suitable shelter would be erected for staff away from where people who used the service could access.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation process for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

A relative told us that staff communicated with their family member well and said, "As long as [staff] say what they are about to do that's fine otherwise [my relative] gets upset."

A staff member said, "People have rights and can choose to refuse care. If they do I would perhaps ask them after 10 minutes if they would like help to get washed and dressed."

People's consent to care and treatment was sought in line with legislation and guidance. We observed staff sought consent before they supported people and respected their wishes. For example, a staff member saw that a person was seated in direct sunlight and asked them if they would like to move; the person indicated using facial expression and the staff member moved them. The staff member checked the person was comfortable in a different part of the lounge. At lunch time, we saw a staff member helped a person to choose from two plates meals that were shown. This showed that staff understood the importance of people's rights and choices.

Records showed that people who used the service had mental capacity assessments in place with regard to making certain choices and decisions. When people lacked capacity to give their informed consent, the law required registered persons to ensure that important decisions were taken in their best interests. A part of this process involved staff consulting closely with relatives and with health and social care professionals who know a person and have an interest in their wellbeing.

The registered manager told us nursing and care staff had been trained in the Mental Capacity Act (MCA) 2005, though we could not confirm this as we had no access to the training matrix. The registered manager had ensured that 21 people were protected by the DoLS. Records showed that the registered manager had applied for the necessary authorisation from the relevant local authority. Some people had been represented by a family member. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person adhere to the main

principles of the MCA and act as a safeguard for the person's rights.

When we spoke with care staff they recalled who was subject to a DoLS restriction. Care staff told us that they felt they would be able to recognise if a person's liberty was potentially deprived and required a DoLS application to be completed.

Is the service caring?

Our findings

Throughout our inspection visit we observed instances that showed people's dignity and privacy was not always maintained or respected. For example, when we arrived at the service one person was seated at the dining table with porridge around their mouth and on their apron. The person appeared to have finished their breakfast. Although staff were around in that area they were focused on tasks and no attempt was made to support this person.

We saw other instances of people's dignity not being maintained. We saw a person was asleep in bed. However, their dignity was compromised because their lower body was left uncovered and their bedroom door left open. We noted that the door had been left open all day as no staff member attempted to ensure this person's dignity was maintained. It was unclear whether this person preferred not to wear undergarments, remain uncovered and have the bedroom door left open because it meant staff could check on them. The person's fire risk assessment that stated '[bedroom] doors to remain open for staff observations when the service user [person] in bed'. There was no additional information about person's opinion being sought or choice being offered.

Another person told us that they preferred to wear loose fitting clothing. However, a towel was used to cover them below their waist. When asked about their choice of dressing and how staff maintained their dignity they shrugged their shoulders and said, "That's just how it is here."

We observed a lady being transferred using a hoist without having a privacy blanket to cover them. Staff did not attempt to give consideration to the person's dignity, and would suggest this is common practice. We later saw staff had placed a blanket over the person's lap to cover their legs. We spoke with the registered manager who said staff will be prompted over peoples' privacy and dignity and this would be discussed at staff meetings and observations by senior staff would be on-going.

We found staff were knowledgeable about the support people needed but did not always speak about people in a respectful way. For example, staff were heard saying "[Person's name] is demanding" and "they don't mind waiting." This showed that staff's approach to care was not respectful or led by the needs of people who use the service.

At lunch time people were asked if they would like an apron. One person had their own fabric apron, which was stained. A staff member offered a clean apron but the person declined and continued to use the stained apron. Whilst this person had made a choice it showed that stained aprons were not washed after each meal.

The provider did not ensure that people's privacy was maintained. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's dignity was not maintained.

We did observe some staff took care to ensure people's dignity was maintained. For example, staff discreetly spoke with people to enquire if they needed to use the toilet and assisted them when they agreed. At lunch

time a staff member offered a paper napkin to a person so they were able to wipe their mouth after finishing their meal.

We saw people were dressed in clothing of their choice. One person said, "I like to wear nice clothes." Another person said, "I like to wear shorts and t-shirt when it's hot." A relative told us, "[My relative] is always well dressed and has usually had a shave." A staff member explained they would show two outfits to help people choose what to wear. We were told that the consultant was working towards being a dignity champion and would apply for the local authority's dignity in care award.

People's care files were kept secure however, information about people's needs were not always secure. For example, details about two people's dietary needs were displayed in the dining room. That showed that provider was not complying with the Data Protection Act. We asked the registered manager to show us the confidentiality policy, but they could not do so. The registered manager said they would remove the confidential information that was on display in the home.

People were mostly complimentary about the staff and felt they had a good relationship with them. One person said, "It depends who's on but they all do respect me." Another person said, "I like [staff names]; they are good to me and help me. I like talking to them because they listen."

We observed staff members spent time with people in a meaningful way before and after lunch. When a staff member asked a person about what their favourite meal was, the person spoke about the local chip shop in an area of Derby which they frequented. Another staff member spent time with one person looking through a book which was of interest to them. Again the person was able to communicate their experiences. A further example was when a person was being hoisted, the staff chatted with them and reassured them during the move as they became anxious. Staff then made sure they were seated comfortably with a drink, and said, "It's warm today you need to drink more." These examples showed that staff took an interest in people's lives and promoted stimulating conversations and emotional support.

People we spoke told us that they had been involved and made decisions about their care but were not always aware of their care plan. One person said, "I have had a say in my care. I have a care plan but staff don't always follow it [in relation to the texture of food prepared]." We spoke with the registered manager who said he would follow this up with the staff concerned. We saw some people made day to day decisions about how they spent their time. A relative said, "I have been involved in [my relative's] care. Staff do contact me if [they] are not well."

People could use the suggestion box at the service. However, people and relative we spoke with were not able to tell us about how their views about the service were sought. We spoke with people and their relatives, none could remember having a questionnaire from the management team from the home. We asked the registered manager and consultant to send us the minutes of service user meetings, they did not do so.

Is the service responsive?

Our findings

People and their relatives told us they felt the staff had got to know people well since they had moved into the home. We saw people, and where appropriate their families, had been involved in care planning and provided information about allergies, likes, dislikes, and past life histories.

Care planning was not person centred and did not reflect people's support needs accurately. We looked at people's care plans and found they included pre-admission assessments, which identified most of each person's individual needs. Care planning was generally linked to people's needs which ensured care plans were individualised. However, care plans were not well defined or accurate.

For example, we saw that one person was not wearing anything on their feet in the lounge. This person suffered from a condition which resulted in reduced feeling in their legs and feet. That meant they would not necessarily be able to notice if an injury occurred. We were told this was their choice though this was not recorded anywhere in the care plan. We also saw their 'mobility and skin integrity' care plan, which indicated the person should be seated on a pressure cushion. This was to reduce the likelihood of pressure areas forming. The person was not sitting on any pressure relieving cushion. We were told this was their choice and this was not recorded in the plan.

We looked at another person's care plan which indicated they had a 'wound' to their foot. The 'skin integrity care plan' stated four hourly repositioning was required to relieve the pressure and stop the wound worsening. Then on the same page two hourly repositioning was referred to, and that the person had 'refused' to be turned and checked but had agreed small movements so that staff could monitor the condition of the person's wound. Consequently, it was unclear how staff were to meet this person's needs with regard to their skin integrity.

A recent review of the care plan indicated that staff were to 'change dressings to heel as required'. We spoke with the nurse on duty but they did not know the current treatment the person was receiving. We spoke with the registered manager who indicated the nurse had not been on duty for a week, but they did not know the current treatment plan either. The latest care plan review stated that the 'wound' should be re-assessed again indicating a 'wound' was present. However, this was not the case, there was no wound and the documentation was poorly kept and did not give the correct information which left the potential for a wound to form and not be noticed, properly recorded or treated. We spoke with the registered manager who agreed to review the whole care plan.

We looked at three people's care plans who were specifically admitted for end of life care. Neither of the three people had an end of life care plan in place. That meant that people's wishes were not written down and information vital to their beliefs may not have been planned for and acted on at the time of their death. The registered manager said staff were included in the monthly end of life meetings however there was no minutes of the meetings and no confirmation who attended them. We did find some guidance about end of life care, however this document (Palliative Care Guide NHS) and was dated 2011. This does not show the home was responsive in organising people's end of life care and provide them with a dignified and planned

end to their life. We did find some end of life information in other care plans we viewed. This had been arranged prior to the person being admitted to the home.

There were inconsistencies with a 'psychological care plan' which mentioned that the person had a 'low mood at times'. The plan advised staff to respond promptly to this person's repeated questions as this helped reduce the potential for behaviour that challenges staff, which was assumed to be due to frustration. We saw that they had been referred for mental health support so a detailed assessment could be undertaken and an appropriate care plan devised to enable them to manage their frustration and low mood, that in turn lead to the person challenging staff.

Another person raised concerns with us about some specialist equipment required to sustain their life. The care plan for breathing did not mention the need to check the equipment to ensure it was working properly. The plan stated that person usually felt hot and was unable to maintain their temperature independently. The plan mentioned supporting the person by closing the bedroom door which contradicted their preference to have the windows and doors open. This meant the care plan was not person-centred and did not take into account the person's anxiety and how to minimise this. Reassurance was mentioned in the care plan review, but not how staff were meant to provide this.

One member of staff told us, "Care plans are kept near the office; we don't always read them but complete the daily books about the care provided." That demonstrates that staff are not always aware of care plan updates. Staff had access to people's plans of care and received some updates about their care needs through daily handover meetings. Staff we spoke with demonstrated their knowledge of people's needs. One member of staff said, "I got to know people by speaking with them and read the care plan, like how much thickener to use". A second said, "There's very poor communication at handover." We spoke with the registered manager and consultant about the staff comment. The consultant said, "I can't understand that." The registered manager said they would follow this up and ensure communication was clear.

We also viewed the staff handover books, these were not person centred and contained inappropriate language such as 'aggressive' and 'refused'. We spoke with the registered manager who said he would instruct the staff to use suitable alternatives.

The service was not responsive to people's care planning and support needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive person centred care.

The registered manager was unaware of the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider did not understand their responsibility to comply with the AIS. However, the registered manager was able to access information regarding the service in different formats to meet people's diverse needs, and spoke about communicating with speech and language staff (SALT) and providing people with alternative means of communication such as pictures. Staff knew people's individual communication styles, abilities and preferences. It was unclear whether information was available in formats that people could understand. We saw staff listened to what people had to say and gave them time to respond to questions. The registered manager did not fully comply with the AIS.

Activities were not well organised or planned in advance. One person commented in a recent questionnaire, "I would like to know what options are available to me entertainment wise." This comment and others had not been followed up by the management team and no activity plan was in place at the visit.

We saw some people were engaged in activities in the home, however there was no activity plan to specify what was available for people to do. A member of staff started a game of bingo, however a number of people fell asleep or became disinterested during the game. We spoke with one person who wanted to play but was not allowed to as the game had already commenced. There were no planned individual activities for people with dementia or memory problems. This does not provide people with person centred care that stimulated them and provided activities in line with their interests. The registered manager said they had employed a person to undertake activities with people and they were starting work at the home in the next few weeks.

The registered manager said there was a flexible policy for visitors, with people being able to visit at most times including meal times. The registered manager said the only time people would be asked to wait was when the person was being assisted with personal care.

The provider had systems in place to record complaints. One person said, "I haven't got any complaints. If there's a problem the staff normally sort it out." A second person said, "I can't complain." A relative said, "If I needed to say anything I would tell [the consultant] or one of the carers."

People we spoke with said they knew how to make a complaint, some said they would speak with a member of staff. The relatives we spoke were aware how to make a complaint, and were aware who to approach in the staff group to have these followed up. Records showed the service had received four written complaints in the last 12 months. The registered manager said that any complaints would be responded to in line with the home's policy and procedure. We saw the latest complainant had been contacted with an explanation in writing; however, we could not ascertain how the other three complainants had been contacted. The registered manager said all had been written to with a full explanation and were satisfied with the outcome, however there was no record to show this. We also noted that comments made in the quality assurance questionnaires were not seen as complaints, not recorded and not dealt with effectively.

Is the service well-led?

Our findings

At our two previous inspections the homes rating has been Requires Improvement (RI). In March 2016 all 5 Key Questions were rated as RI and at the following inspection in May 2017 Safe, Caring and Well Led remained RI. There were no breaches at the previous two inspections.

The provider did not send in an action plan following the last inspection, so we were unable to check what progress if any had been made since the last inspection.

At this inspection we found effective systems were not in place to assess and monitor the quality of care. We asked the provider about the quality assurance checks he undertook in the home, and he replied he did regular checks. However, though there was some audit systems in place, they were not used effectively or reviewed regularly by the provider, and no action or improvements were put in place by the provider.

There were no infection control protocols to instruct staff how to properly clean and disinfect areas in the home. There were no cleaning schedules to instruct the staff how areas of the home should be cleaned and disinfected. An infection control inspection and 'environment check' had been undertaken by the registered manager. We viewed the completed reports but these did not reveal the extent of the issues we found in the home, which would indicate the checks were not comprehensive enough to reveal shortfalls. For example the wooden toilet raisers were not mentioned in the 'check'.

Information from accident reports were collated, but these were not recorded in a way that would reveal patterns where alternative strategies could be used to reduce the likelihood of accidents re-occurring.

There were other areas that were not included in the quality assurance processes with shortfalls in staff supervision, care planning and records complaints and the accessible information standards not being recognised or actioned by the management staff.

The provider had failed to make sure quality assurance systems were in place to ensure that records and other aspects of the service had been thoroughly monitored to protect people from harm and ensure their safety. This was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and a visiting relative told us they had a good relationship with the registered and other managers and staff in the home. One person said, "[Consultant] is around if you need to talk to her." A second person said, "I want the communication between staff to improve; they don't pass on messages." We passed the comment onto the registered manager who said he would follow this up. One relative said, "I think the home is run well [my relative] has been here a few years and their needs are met."

We spoke with the registered manager about the visions and values of the provider. He said the management team had produced an action plan of areas that needed improving which they were working toward completing. They told us about the 'treats' supplied to the staff on a regular basis. For example,

while we were inspecting, crisps were provided for staff, we were told occasionally burger meals were also provided. The registered manager stated that he regularly treated the staff in his appreciation of their work at the home. None of these areas went toward the vision and values of a home delivering high quality care.

Staff provided mixed comments about the efficiency of the management team. One person said, "[Named] and the manager has made some progress to improve this place." A second person said, "It's improved a lot since [consultant] joined and they work well with [registered manager]."

Some staff felt the staff meetings were not productive, as there was conflict between the staff. The registered manager had a staff meeting recently to address personality conflicts between staff in an attempt to address this issue.

Staff told us about areas they would like to see improved. They felt they required more training on multiple sclerosis (MS) and Parkinson's disease. They also felt there were not enough activities for people and felt the addition of a tea trolley for the ground and first floors would improve the temperature of drinks.

We found the management team lacked an understanding of current best practices to provide safe and effective care. The management team appeared to be unaware of issues we found, such as infection control risks, risks within the premises and lack of facilities (bathrooms), dignity issues and lack of awareness regarding properly deploying staff or having a consistent staff rota.

People who used the service and their relatives were enabled to contribute to the quality assurance process and quality of care in the home. Comments from questionnaires was discussed with staff, but there was no evidence that the people who made the comments had anyone contact them with a resolution.

Questionnaires were distributed to people and their relatives so they had the opportunity to comment about the quality of service offered by the home. There were a number of positive and negative comments, however there was no evidence of comments being followed up. One such comment related to a person's food choice not being available, this and other comments were not recorded as complaints or acted on to resolve the person's difficulties. Other comments included, "I am so happy being here and see it more of where I live than being in a nursing home and I look at everyone as being my friends rather than carers." A second person said, "Room for improvement, I do not always get my mail or messages. I do not understand why mailbox is not emptied and then mail run round the home." A third person said, "I have never been asked what I can or cannot have in my room." The registered manager stated they spoke with those people who had made comments but had not recorded when or the changes that had been made as a result.

There was a collated summary from each annual questionnaire however this was not circulated to people in the home or their representatives. The registered manager said he would do this following the next questionnaire that was being sent out.

The registered manager said there were no meetings for people who lived at the home or their relatives. They said, "These have not been popular" and explained they were not well attended so staff stopped organising them. That meant the provider had failed to involve people fully in the quality assurance process which does not reflect a service that seeks to learn, innovate and ensure sustainability.

We saw there were mixed opinions of the staff group from the latest staff questionnaires. One staff said, "Negative environment to work in, friction between staff." A second person stated, "Managers welcome staff to sit and talk if there is a problem." And a third, "I feel my opinions are listened to." And a fourth, "I can't imagine working anywhere else."

We saw a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Records showed that most essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. However, the registered manager still had to call in electricians to deal with some outstanding electrical work which we discovered had not been completed.

Staff reported policies and procedures were kept in the office but said they were not readily accessible. One staff member stated that when they raised a staffing issue with the registered manager they had dealt with the issue.

We approached the commissioners who funded people's care packages prior to our visit. The local authority is working with the provider to overcome some concerns they raised at a recent monitoring visit.

A copy of the last inspection report was not displayed in the home, however it was quickly produced after our arrival. The registered manager said it had been removed when the foyer was decorated. The last report contains the rating from the last inspection, and it is a requirement for all residential and nursing homes to display this following the last inspection.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support plans were poorly compiled, unclear and lacked detail.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not maintained.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The storage of some medicines was not well organised and staff did not adhere to best practice when disposing of excess and out of date stock. Infection control was not well organised, and people were placed at risk from cross infection and cross contamination.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not act on allegations of alleged abuse and report them onto the appropriate body for investigation.

