

Haldane House Limited

Haldane House 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?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Haldane House is a care home with nursing. It provides accommodation and nursing care for up to 25 people. Some of the people using the service are living with dementia.

People's experience of using this service and what we found

The registered person did not ensure systems were in place to oversee the service and ensure compliance with the fundamental standards. The registered person did not always ensure they maintained clear and consistent records when people had injuries to evidence the Duty of Candour was applied.

The management of medicines was not always safe. Risks to people's health and wellbeing were not consistently assessed and staff did not always follow guidance to support people in the right way. Staff's deployment was not always managed effectively as we observed at times people, who required support, were left alone with no staff presence. People's safety was compromised in the service as some parts of the premises were not well maintained.

The registered person had not ensured staff were provided with appropriate training as was necessary for them to do their job safely and effectively. Staff said they felt supported to do their job and could ask the manager for help when needed. People were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service were in place but did not support this practice.

People and relatives made some positive comments about the staff and the care they provided. However, we observed a mixture of interactions between people and staff which did not always show kind, caring and friendly practice. We also observed occasions where staff did not uphold people's privacy or respond in a way that maintained people's dignity. People and their families felt they were not always involved in the planning of their care. People's and relatives' feedback was not always sought to make improvements to the service.

The registered person did not ensure activities were more personalised and people had opportunities for social engagement according to their interests to avoid isolation. We have made a recommendation about seeking guidance from a reputable source to ensure the principles of the Accessible Information Standard were met.

There had been management changes since the last inspection, which affected the service management. The new manager had reviewed paperwork, systems and processes to ensure they could review, assess and monitor the quality of care in a consistent way. There was progress in making various improvements but not sufficient at the time of the inspection for us to judge this would be sustained.

People felt safe living at the service. Relatives felt their family members were kept safe. Staff understood

their responsibilities to raise concerns and report incidents or allegations of abuse. They felt confident issues would be addressed appropriately. Recruitment processes were in place to ensure as far as possible, that people were protected from staff being employed who were not suitable. The equipment was clean and well maintained. The dedicated staff team followed procedures and practices to control the spread of infection and keep the service clean. There were contingency plans in place to respond to emergencies.

People were able to access healthcare professionals such as their GP. The service worked with other health and social care professionals to provide effective care for people. People had sufficient to eat and drink to meet their nutrition and hydration needs. Hot and cold drinks and snacks were available between meals.

Staff felt the management was open with them and communicated what was happening at the service and with the people living there. People and relatives felt the management of the service had improved and that they could approach manager and staff with any concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 15 March 2017).

Why we inspected

This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to 9, 10, 12, 18, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 at this inspection.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Haldane House Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was carried out over two days by one inspector, an assistant inspector, a specialist advisor and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. For example, in this inspection, caring for people with dementia.

Service and service type

Haldane House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The manager of the service we met during our inspection has started couple of months ago and was still in the process of applying to register. We will refer to him as the manager in the report.

This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. In the report we will refer to them as the registered person.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Before the inspection we looked at all the information we had collected about the service including previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who use the service and seven relatives. In addition, we spoke with the manager, the deputy manager, and six members of the staff team. We observed lunch, planned activities and interactions between staff and people living at the service. We carried out a tour of the premises.

We looked at eight care plans, daily notes and other documentation relating to people who use the service. We also looked at Do Not Resuscitate forms for all the people. In addition, we looked at the records related to the running of the service. These included medicine management, five recruitment files, staff supervisions, health and safety records, incidents and accidents information, compliments and complaints, and quality assurance audits.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data, team meeting minutes and further quality assurance records. We sought feedback from the local authority and professionals who work with the service. We received response from two professionals.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People did not always have their medicines managed safely.
- According to the provider's controlled drugs policy, two staff were required for dispensing and checking the controlled drugs. However, we observed one of the senior staff dispensed it and signed the book. The staff then called another senior staff member to countersign the medicine in the office after it was administered.
- People had plans in place for 'as required' (PRN) medicine. However, the information to guide staff was not always clear regarding side effects, any other options to support people and when to administer the medicine to ensure people were not being given excessive medication. For example, one person had to have medicine for increased anxiety, irritability and aggression. However, there was no record of why the person had been given the medication and what was done before administering the medicine to try and calm the person without medication.
- There was a fridge where various medical products like insulin were kept; the temperature of the fridge should be checked daily. We observed one of the senior staff filling out the temperature check record gaps retrospectively. This meant temperatures were not consistently checked to ensure medical products were kept at a safe temperature.
- People were supported to have their medicines at the right times as prescribed. However, we observed one person being given all of their medicine at once into their mouth. The senior staff tapped them on the shoulder and said, "Drink some water". This was not safe practice nor was it part of the care plan.

The unsafe management of medicine placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Controlled drugs stock was checked weekly, the record for it was accurate and appropriately signed. The senior staff carried out a monthly audit of both controlled drugs and medicine stocks. We reviewed medication administration record sheets and we did not find any gaps. People's medicines were reviewed six monthly or as required by the pharmacist and GP.

Assessing risk, safety monitoring and management (people)

- We found risks associated with certain aspects of care were not always monitored or managed safely. For example, one person's initial assessment indicated they had epilepsy. There was no specific plan of care, assessment or guidance to help staff support this person to manage risks around the condition. In the care plan about maintaining a safe environment and risk of falls, it said the person was at high risk of falls and suffered from "epileptic fit". There were no further documents about how to support the person safely with their epilepsy.

- Another person was at high risk of falls according to the risk assessment tool for falls. However, there was no clear guidance on how to prevent the person from falling and manage those risks.
- We observed staff not following guidance in relation to supporting people to bathe safely. Staff were not recording the temperature of the bath to demonstrate that it was safe. The manager told us they addressed this with staff after the inspection.
- The service was moving all paper records to an online system. We looked at the paper copies of people's care records for those who did not have it online yet. Where risk assessments were noted to be in place in paper files, it was not available in the paper file or online. This meant the registered person did not ensure guidance on risk mitigation and management was in place for people to keep them safe.
- Without accurate and consistent information there was a risk staff may not be aware of how best to support people to ensure their safety and wellbeing.

The registered person did not ensure care and treatment was provided in a safe way. They did not ensure risks to health and safety of service users were assessed and mitigated at all times. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management (premises)

- We reviewed what premises and maintenance checks were carried out. We found the electrical wiring certificate indicated the last inspection in August 2017 was unsatisfactory. We asked if any further inspections had been carried out, but the maintenance staff confirmed there had been none since August 2017. During our inspection the staff contacted the electrician who agreed to visit the premises and get this completed in two weeks' time.
- In November 2018 there was a visit from a Fire Officer who identified areas for improvement. One of the areas to improve was to carry out regular fire drills, day and night, in order to assess whether people could be moved in a reasonable time to a place of relative safety. Only one fire drill was carried out in February 2019. The registered person did not ensure the action plan from the Fire Authority was fully completed so they could be sure staff were able to support people safely during an evacuation. We informed the manager who planned a fire drill after our inspection.

The registered person did not ensure all actions were completed in a timely manner to make the service a safe place to provide care and support to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We reviewed other checks carried out on premises and maintenance and these were completed. Maintenance staff monitored other general environmental risks, such as water temperatures, fire exits and slip and trip hazards as they went about their work.
- Business continuity plans were in place to ensure people were supported in the event of emergency. However, we asked the manager to review some parts of it as it had out of date information or unclear instructions for staff.

Staffing

- Staff were not always deployed in a way that kept people safe or supported people appropriately to meet their complex needs.
- The manager said they used a dependency tool for calculating staffing numbers on each shift according to the needs of people. The manager also said if people needed to go out, extra staff would be arranged to cover the shift or the outing.
- We received mixed feedback from people. They said, "Not always [staff available], they're quite busy. Would eventually get one (come into lounge)" and "Yes, most of the time. I have a call bell at night, I press it

if I want them and they come quite quickly."

- Relatives told us the staff regularly left the lounge to have their lunch all together in the dining room leaving people in lounge unattended. During our inspection we also observed staff eating their meals all together leaving the lounge full of people with one or no staff. We noted this to the manager who addressed this with staff to ensure breaks were arranged to suit people's needs and support.
- Staff felt there were enough staff to help carry out their role and responsibilities.

Learning lessons when things go wrong

- There was a system for recording accidents and incidents. The manager monitored accidents and incidents by using a monthly matrix, and this was reviewed every six months.
- Incident and accidents were recorded and investigated, but action was not always taken to prevent reoccurrence. For example, we saw that one incident resulted in an action to discuss learning in a team meeting with staff. However, this discussion and learning had not taken place.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe and relatives told us they felt their family members were safe. People and relatives said they would tell staff if someone did not feel safe.
- People said, "They [staff] look after you, I've got nothing to worry about, that's the main thing" and "Oh yes, they watch very carefully, they watch the front door." Relative said, "They [staff] are aware of security. There's always someone around here, they look after [my relative's] needs", "Oh [my relative] is so safe here. It's not posh, it's homely, and the staff are amazing. They know all the visitors and you're made to feel so welcome" And "Yes definitely. It's one of the reason's [my relative] came in here, she wasn't safe at home."
- When there had been safeguarding concerns raised, the manager dealt with them appropriately.
- Staff were aware of how to deal with and report any issues relating to people's safety. Staff were confident the management team would act on any concerns reported to ensure people's safety.

Recruitment

- We looked to see if safe recruitment procedures were used to ensure people were supported by staff who were of good character, suitable for their role and had appropriate experience. We found discrepancies with a few gaps in employment histories, current photograph as proof of identity and checking of fitness to carry out the roles. We raised this with the manager and they provided information this had been rectified.

Preventing and controlling infection

- Everybody we spoke with thought the service was clean and maintained. One person said "Yes, the rooms are cleaned every day and the beds are made."
- There was a daily cleaning schedule, and cleaning audits completed. The environment was clean although we noted some staining on chairs.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans did not consider the full range of people's diverse or complex needs. This meant people would not always receive effective care and support from staff. Staff were not always guided by best practice and specific guidance for each individual.
- Some people experienced behaviour that may challenge others. Their care plans did not always provide the required information for staff to identify triggers and appropriate interventions to prevent the behaviours escalating. Charts to record people's behaviours that may challenge did not always accurately reflect the detail in people's daily notes. Staff did not review people's behavioural charts or records to identify the specialist support required to meet their needs. The manager said the mental health team would read through these records to monitor and review people's behaviour.
- The registered person did not always ensure care and support reflected current evidence-based guidance, standards and best practice. A person had mental health issues including fluctuating capacity. We found the person had a form for "do not attempt resuscitation" (DNAR) signed by a senior staff member and visiting GP. The reason given for DNAR decision was a specific condition and "a poor quality of life". We queried this with senior staff, but they were unable to give us an explanation of the reason recorded on the document. We looked through the records for this person and found the staff recorded the person actually was quite well and happy living in the service. We raised this with the manager and he has agreed to take this back to the GP to review.

The registered person did not ensure people's care and treatment was appropriate and met their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans such as communication, likes, dislikes, or dressing described in detail the outcomes people wanted to achieve, how they wished to be supported and level of involvement.

Staff support: induction, training, skills and experience

- We reviewed the training matrix provided to us, which recorded training the provider had determined was mandatory, as well as role dependant training for care staff and for the registered nurses.
- Staff did not always have the training they needed to meet people's needs and ensure their safety. For example, not all staff had received up to date training in relation to safeguarding, medicines, manual handling, MCA and Dementia care. The manager informed us after the inspection they had arranged medicines competency assessments for staff.
- This meant the registered person did not ensure people received effective care and support from staff who had up to date training. This put people at risk because staff were not guided by best practice and up to

date knowledge.

- During our inspection we observed interactions between people and staff where people needed to be supported to manage their behaviours. We observed staff did not always respond to people's needs so they could have positive outcomes, such as utilising an effective approach to help a person calm down. We could not be sure staff had sufficient understanding of how to support people in such situations.
- Some staff told us more detailed training on mental health care and behaviours that may challenge was required. It would help them understand and support people better, especially in situations when people became anxious or distressed.

The registered person did not ensure all staff supporting people were appropriately trained in order to perform their work. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the new manager came in the post this year, they have arranged a number of training sessions with an external provider as the training was out of date in most topics. They had also arranged eLearning training for staff to complement classroom sessions.

Adapting service, design, decoration to meet people's needs

- There were people living with dementia in the service and there were minimal adaptations for them to promote independence. For example, there was no dementia signage or use of contrasting colours to enable people to find their way around and identify toilets and other rooms.
- There was little evidence of sensory stimulation for those residents who have dementia. The walls displayed basic accessories and sensory gadgets such as large calendars and clocks or aids to prompt memory recall, however it was not in line with guidance to support dementia friendly environment. We noted to the manager the clock on the wall in the main lounge was keeping the wrong time
- The premises were clean and maintained, however, some fixtures, furnishings and furniture was not always of a good quality. We saw people did not have any signs of significance to them or pictures on their bedroom doors to help them identify which room was theirs. One door did not have a name at all.
- Some communal toilets and bathrooms had signs on the doors, but they were very discreet signs and would not help people with dementia identify the room was a toilet if they were looking for one.
- There were no way-finding signs to help people find their way around. During our inspection we observed people wandering and they were not sure where to go as we had to find staff to help them.
- Other aids that could help with people's wellbeing were not present, such as coloured crockery used to support some individuals when eating. Other colour coding to aid independence was also missing. For example, using colours to highlight light switches by either having coloured switches or making sure white switches show up against the wall colour helps people to find and use light switches in their rooms independently.
- The manager had carried out an environmental audit before our inspection and identified similar issues. The service was undergoing refurbishment in several phases and part of the plan was to make the environment more dementia friendly.

Ensuring consent to care and treatment in line with law and guidance

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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- We observed staff were polite and respectful towards people and their decisions. Most people said staff asked for consent before doing anything to help them. However, one person said, "Staff just walk into my bedroom."
- Relatives thought staff asked their family members for consent before delivering care. They said, "Staff tell [relative] what they're going to do before they do it" and "[Relative] will only allow the male carer or one or two other staff to do his personal care."
- People's rights to make their own decisions, where possible, were protected. From the care plans it was clear staff were aware of the need to engage with people in decision making and where this was not possible, act in the person's best interest. Staff were able to explain how they sought consent and ensured people could make decisions.
- Some MCA assessments and Best Interest decisions did not always reflect an understanding of the individual and their wishes and were largely based upon perceived risk. However, the manager was updating online records and demonstrated an understanding of the situation and the need for time and decision specific assessments.

Supporting people to eat and drink enough to maintain a balanced diet

- People said they enjoyed the food and had plenty to eat and drink. People said they could ask for something else if they wanted to. They had four meals a day and regular drinks throughout the day.
- Relatives told us the food was good. One relative said, "It's good, home cooked food", "Staff are very patient when they [help my relative eat]. They also give her Ensure and spend time with her until it's gone." ● We observed lunch time and people were supported to eat at their own pace having small chats with them at times. We also noted to the manager the menu near the dining room was hand written and some parts of it we could not read.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- From the records we saw people's changing needs were monitored to ensure their health needs were responded to promptly. People were referred to various health professionals in good time to address any health or changing needs.
- The GP visited the service weekly to support people with any health ailments and queries from the staff. The service also worked with professionals such as opticians, chiropodists, dieticians, dentists, mental health professionals, hospice care staff, physiotherapists and continence specialists.
- People had medicine reviews carried out by the GP to ensure they were on the right and effective prescribed treatment.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff did not always show concern for people's wellbeing in a caring and meaningful way and did not respond to their needs quickly. We observed how staff supported people who could become anxious and exhibit behaviours which may challenge others.
- We reviewed the care plans regarding how people wished to be supported and found they were not always followed. For example, one member of staff held a person by the wrist and removed a cup from their hand, rather than getting down to their level, speaking calmly and gently with them to reduce the person's agitation. The care plan indicated the person would benefit in such situations to talk about things that interested them or things they used to do. This was not tried by the staff.
- We observed another person walking around the lounge, swinging the door back and forth while seated or fidgeting with a door handle. Part of the care plan for this person described how best to support them so they could engage meaningfully with staff or others. However, we did not observe staff present responding to this behaviour in a caring and sensitive way according to the care plan.
- We observed one person wandering around the service throughout our inspection. We had to ask staff couple of times to check where the person wanted to go, what they wanted or prevent them from an injury on one occasion. The care plan for this person indicated they needed to be observed and provided with reassurance and emotional support if signs of distress were present. As the staff were not observing the person, they could not provide timely support to this person and prevent them getting distressed.
- We observed when people's privacy was not upheld. For example, we heard how one of the senior staff was discussing private health matters with a relative in the lounge full of other people. They did not consider taking this relative and person to a private area before explaining those changes.
- One relative told us often the equipment not belonging to their relative was stored in their bedroom.
- We observed staff were responsive to people depending on what people needed. However, they were more task orientated and were clearly very busy getting the tasks done. Thus, staff did not always respond to people in a manner to ensure they were able to offer sensitive and respectful support and care.
- Looking at the care notes in people's daily records there was lack of continuous and clear evidence to indicate people were supported appropriately to ensure they remained calm and enjoyed their stay in the service.
- Where people became agitated or stressed, this was not always recorded and sometimes lacked information of what was done. This meant the manager did not have an overview of people's conditions, their wellbeing and would not be able to seek appropriate support if needed.

The registered person did not ensure people were treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

- We also observed there were times when people were treated in a kind and caring way when staff were supporting them. There were examples where staff spoke calmly and politely giving people time to respond. One these occasions it was evident some staff knew people well. For example, on one occasion a staff member supporting a person appropriately whilst they were walking, or they spent some time in their room and they both were engaging in a conversation. The person was enjoying the company and time spent with staff.

- We observed staff tried to encourage one person to go and have a bath. Staff tried gentle persuasion with appropriate touch, good eye contact and a calm tone of voice to support a person.

- People said staff were kind and caring when they were being supported, and said staff knew how they liked things done. People said, "They know their job and they do it well" and "They know me, I've been here so long. It's very homely here."

- Relatives said staff knew the preferences of the people they supported and felt that their family members were cared for well. They said, "Oh, they know [relative], definitely. She's clean and tidy, her clothes are always nice", "They are very caring, which makes you feel safe. [Relative] responds to [X staff], she smiles at him. Staff know our names and remember [relative] talking about her family."

Supporting people to express their views and be involved in making decisions about their care

- Not all relatives were aware of or involved in their family members' care plan process. Relatives said, "Lots of meetings at first when [relative] was in and out of hospital, but not a care plan", "[Relative] came here in rather a rush, it was done as an emergency. The previous manager came out to the house and talked to him", "I looked at it early on, things would have been changed now as [relative] is hoisted. I've never had a formal review here, it's something I would appreciate."

- One relative said they did not know what medicine their family member took as part of the care plan as they have noticed a change in them. They told us they would like to know more about their care plan. Another relative said that "Yes, I did go through it with them."

- None of the people said they were involved in their care planning and reviewing. Only one person said, "No, but they [staff] fill them in every day. They use iPad and it goes straight to the computer. Everything you do gets put down."

Respecting and promoting people's privacy, dignity and independence

- People's social needs were not always understood. We observed there were times people were sitting in the lounge and no interactions were taking place. People who were easy to engage in conversations received more attention from staff than those people who may have needed a different approach to help them engage in activities or conversations.

- We observed that music was often playing loudly. One person wanted to change the channels on television in the lounge. One staff said, "Leave it, leave it, leave it". Another staff came into the lounge, took the remote off the person and put it on the top of the picture frame, then walked out of the room without saying anything. The person was left quite confused as no one explained what happened and the reason for it.

- However, relatives and people told us they were treated with respect and their dignity was protected. People said, "They talk nicely to me" and "They always knock on my door and make sure the doors are shut when I'm in the bath. I wash myself the days I don't have a bath."

Relatives said, "Definitely, yes. It's their manner, they're very kind and caring" and "Yes, e.g. if [relative] is on his own, they (staff) will go and sit with him."

- People's bedrooms were personalised with pictures of friends and family, paintings, books and other items important to the person. The service was not very spacious, but it allowed people to spend time on their own if they wished. We observed people and their appearance. They looked well cared for with clean

clothes, hair done, and people wore appropriate footwear.

- All personal records were stored on the computer with password protection and kept locked away and were not left in public areas of the service. Therefore, people's right to confidentiality was protected.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were based on a full assessment, with information gathered from the person and others who knew them well. Where a care plan was in place, it clearly described people's abilities, likes, dislikes, preferences and wishes, support needed, and desired outcomes.
- We noted to the manager the care plans were person centred in some areas, but some information was not accurate. For example, for one person their oral assessment indicated they did not use dentures. However, in the care plan for dressing, it was noted how to support the person with denture care. The person was assessed as being at very high risk of pressure damage, but the care plan said it was high risk.
- Another person had mental health needs, but the care plan did not have sufficient information about this. There was information about the diagnosis but there was very little about the impact of the condition on the person or any interventions required to support them to maintain good stable mental health.
- A third person had a mental health condition. Again, information about the management of it was lacking and would not help staff to understand it. There was a note the person had a past history of self-harm. However, there was no specific care plan or risk assessment in relation to this. Care plans were not always reviewed regularly. This meant staff did not have the most up to date information to guide them to provide person-centred care.

The registered person did not ensure care and treatment was appropriate and met people's needs. This was a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There was some guidance in communicating with people in a manner they could understand. We discussed the AIS with the manager to ensure all information presented was in a format people would be able to receive and understand.
- Staff were aware of different ways of communicating with people, for example, observing body language, using visual aids, pen and paper, or using simple questions.

We recommend the service seeks advice and guidance from a reputable source about meeting all five steps of AIS.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not regularly engaged in meaningful activities and interaction. Activity timetables were not readily available to people to ensure people were able to choose activities.
- We observed when activities were not happening, the majority of the people were sitting in the lounge in a big circle with the television or music on without any activities. Sitting in smaller circles would have encouraged more interactions between people and staff. At times some of staff would initiate small ad hoc activities like playing dominoes or colouring.
- When the television or music on, staff were encouraging service users to clap along however there was not much involvement. We also observed during our inspection the music playing was often quite loud and not very appropriate to the age group of the people living in the service.
- Relatives said, "[My relative] likes her TV" and "I've never seen an overview of timetable of activities. I'd like to be able to tell [my relative] what's going on this afternoon, for example." This relative also thought the television was sometimes used inappropriately e.g. instead of daytime TV, suggested they found an old movie or musical which might trigger memories for people. Another relative said, "They leave the door open for [relative] so he can go into the garden if he chooses. When I visit, they always know where he is."
- We checked people's care plans to see what their likes and dislikes were to match this with the activities provided but there was no evidence that this was taking place. We reviewed six people's records and there was a lack of records regarding activities. Paper files had activity audits done but it was not done since March 2019.
- It was difficult to see from care notes, written and online, if people were doing any activities or if staff were encouraging them to get involved. Even though the service had a programme of activities, some people may not be protected from isolation and there was a lack of stimulation for them. People were not always helped to maintain their emotional wellbeing or encouraged to participate in an activity suited to their needs.

The registered person did not ensure care and treatment was appropriate and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to develop and maintain relationships with people that mattered to them. We observed relatives visiting people throughout our inspection. People could stay and spend as much time as they wanted with their relatives in their rooms, lounge or dining room.
- A relative told us they approached the management several months ago about the possibility of her [relative] having lunch with her family member on a daily basis, as they had dementia. The relative said staff welcomed the family member and now they make sure he sits with his family member having lunch.

Improving care quality in response to complaints or concerns

- The manager took complaints and concerns seriously and would use them as an opportunity to improve the service. There had been one complaint since the last inspection. We were aware the manager was working with other parties involved to investigate and respond appropriately.
- Everyone knew how to raise a concern. All people and relatives said they would talk to two particular members of staff or the manager. One relative said they had some issues with bills before however that has always been sorted out.
- The staff felt they could approach the manager with any concerns should they need to.

End of life care and support

- The service did not always have consideration for, people's individual religious, social and cultural diversity or values and beliefs, and how these may influence wishes and decisions about their end of life

care, so these are not recorded or acted on.

- There was one person receiving end of life care. We spoke with a relative of the person receiving end of life care who said that he 'cannot fault them [staff]'. However, they added that sometimes they were not acknowledged by staff as in need of support except for one senior staff.
- We compared records on paper and online around the care of this person. Paper records had limited information and showed an initial assessment covering all areas of care needs were completed but limited in detail. The assessment process highlighted diabetes as a risk and it was explored in some detail. The care plan did not acknowledge that the relative might need support.
- In contrast the electronic notes and assessments were thorough. It gave detail of identified needs, risks, and interventions required to meet those needs of the person.
- The manager had an interest and specialism in the end of life care. They were introducing Gold Standards Framework (GSF) for end of life care. The GSF Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling frontline staff to provide exceptional care for people nearing the end of life. The manager's knowledge of the GSF care for end of life was reflected in the care plan of the person.
- Other care plans we looked would benefit from more detail exploring people's wishes in regard to the end of life care, any specific wishes and requests or if they did not wish to engage in such conversation at this time.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay.
- During this inspection, we found the registered person did not ensure CQC was consistently notified of reportable events within a reasonable time frame.
- The registered person did not ensure notifications of the outcomes of Deprivation of Liberty Safeguards (DoLS) applications were submitted, as required. There were six people with DoLS in place, but no notifications had been submitted to inform the Commission. This meant we could not check that appropriate action had been taken to ensure people were safe at that time. We asked the manager to submit notifications retrospectively.

The registered person failed to notify the Commission of notifiable events, 'without delay'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. However, there was not one registered at the time of this inspection. The manager we met during inspection had been in post for two months. We spoke with the manager about the progress of the application of registration during our inspection. He explained the progress such as processing his DBS check. We checked our system and the last application submitted was in July 2019 and was rejected due to incompleteness.
- The registered person had a quality assurance system in place that included different audits, so they could assess and monitor the service delivered. However, the registered person did not ensure their quality assurance systems were always used effectively to promptly identify areas for improvement. For example, the audits had not identified the concerns around management of medicine; guidance to staff; activities; and records.
- The provider's quality assurance processes were not effective. They failed to identify all of the concerns found on inspection. Records were not always completed accurately or updated when necessary. The online system and paper files did not always correlate with people's needs. Staff used both systems simultaneously. This was due to some staff not able to use the online system. The manager's plan was to transfer all records online and use one system. Since the new manager came in, information was being transferred to online records only. The manager had begun to review care plans and implement those on the electronic system which was more comprehensive including related risk assessments.

The registered person had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A). This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had defined roles but did not always understand their responsibilities in ensuring the service met the desired outcomes for people. We observed not all staff had the knowledge and skills to support people and their complex needs. From staff feedback, we could see they were interested and motivated to make sure people were looked after well and able to live their lives the way they chose to. We observed some good practice. However, during the inspection we also observed some practice that was poorly managed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager understood their responsibilities in relation to the duty of candour, to be open and honest with people. Since the last inspection, we had received notifications regarding two serious injuries and these had been identified as notifiable incidents. People were supported to go to hospital and update their care and support needs.
- However, the registered person did not ensure the necessary records in relation to these incidents had been completed to demonstrate how the registered person had met their duty of candour responsibilities according to the regulation. We noted the lack of records to the manager and ensure this was part of the improvement plan.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- During our inspection, we were told there had been recent management changes and that this had been unsettling for the staff team. However, we received positive feedback from staff about the new manager. For example, "I am very positive about the new manager and looking forward to developing new skills" and "I look forward to going to work now. [The manager] is amazing and he's like a ray of sunshine."
- The manager had begun addressing various issues identified such as staff training needs and support, paperwork and practice. We were told the manager had an open-door policy where staff felt they could approach him, and he was described as "supportive".
- It was clear the appointment of a new manager had been positive. They had already identified some issues relating to the running of the home, people's care and support needs. They were working with the management team to address these to ensure the service was safer for people and staff.
- People and relatives thought the atmosphere was good and homely. Relatives said, "I haven't met the new manager, I would like to meet and greet with him" and "Since the manager has been here, it's better organised, there's more things on the walls. He does come out of the office, he's quite shy but he's very approachable. He's done a good job already."
- There was a management structure in place, which gave clear lines of responsibility and authority for decision making about the management.
- Everybody thought staff were happy working at the service and there were good relationships with each other. People said, "Yes, we've got some nice staff, they're very helpful and cheerful. It's very homely" and "They've got some very, very good carers, the male one especially, he's a really nice, kind man. Cheerfulness, that's what makes them good."
- Relatives said, "Yes. A lot of the staff have been here as long as [my relative] has. I've never seen any whispering or moaning. The staff all go out at Christmas and know each other's birthdays", "Yes, it's a nice little family", "They're always jolly and get on well together. There's not been many staff changes", "The carers are fond of [my relative] and they are kind to her" and "I've never seen any moodiness in the staff."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The manager promoted a positive, caring, transparent and inclusive culture within the service. The manager said the last survey was done in July 2018, but they did not find any analysis. The manager reviewed the feedback forms again as much as possible to identify any action to be taken from it. They also told us a new format would be used to gather feedback again.
- The staff team had some meetings and discussed different topics including practice at the service, care and support of people, care planning, safeguarding, medicines and training. The manager also held a staff meeting after our inspection to discuss feedback and address the issues we had raised. Relatives and people using the service had not had any meetings yet. The manager said this was part of their action plan to arrange so they could discuss any questions or issues with them.
- The manager praised the staff team saying, "All the staff here are very responsible, aware of their role, and it's like a second home for them. Staff enjoy working here and I feel supported by them." The manager added he felt supported by the senior staff and were working together.

Working in partnership with others

- People's care plans contained records of visits or consultations with external professionals. Those seen included GPs, community nurses, hospital consultants, dietitians, chiropodists and members of the community mental health team. People also could maintain links with local community such as local churches and amenities.
- One community professional said the service was managed well since the new manager had started and they did not have any concerns. We saw the manager established better working relationships with professionals such as having regular contact with GP, mental health team, social workers, palliative care services, dietitians and the local authority.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered person failed to notify the Commission of notifiable events, 'without delay'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person did not ensure care and treatment was appropriate, met service users' needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person did not ensure people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person did not ensure safe care

and treatment. The management of medicine was not safe. They did not ensure risks to health and safety of service users were assessed and mitigated at all times. The registered person did not ensure all actions were completed in a timely manner to make the service a safe place to provide care and support to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A). This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The registered person did not ensure all staff supporting people were appropriately trained in order to perform their work. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.