Berengrove Limited

Berengrove Park 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

The inspection took place on 2 and 3 May 2018. The inspection was unannounced.

People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection of the care home. Berengrove Park Nursing Home is registered to provide accommodation for older people who require nursing or personal care. The home was registered to provide nursing care and support for up to 36 people. There were 31 people living at the home at the time of this inspection. People had complex health needs, including diabetes, stroke and Parkinson's disease. Many people were living with dementia, some at an advanced stage requiring high levels of support from registered nurses and staff.

There was a registered manager in post at the service. 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.

Our last inspection report of this service was published on 21 October 2017 and related to an inspection that had taken place on 15 and 16 August 2017. At the inspection in August 2017, we found breaches of Regulations 9, 10, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two breaches had continued since the previous inspection relating to the management, leadership and monitoring of the service provided and people's safe care and treatment. Three further breaches were found in relation to, people receiving care and support that meets their individual needs; people receiving care and support that respects their privacy and dignity at all times and ensuring staff were deployed to adequately meet the needs of people throughout the day.

We asked the provider to take action to meet Regulations 9, 10, 12 and 18. We took enforcement action against the provider and the registered manager and told them to meet Regulation 17 by 03 November 2017.

The provider sent us an action plan on 18 October 2017 telling us the action they were taking to comply with regulations 9, 10, 12 and 18. They told us they would be fully compliant by 01 January 2018.

At this inspection, on 2 and 3 May 2018, we found that some improvements had been made in all the areas highlighted as requiring improvement. However, further improvements needed to be made and we found other areas of concern not found at the last inspection.

Risk assessments around people's personal and nursing care needs were in place. However, these continued to primarily focus on the areas of risk common to most people living in the service and did not reflect individual or changing needs. Health and safety hazards were observed around the premises. The

control of infection within the service was not clearly managed or understood by staff.

Some elements of medicines management needed improvement in order to provide a safe and effective service when administering people's prescribed medicines.

Mental capacity assessments had been undertaken to ensure people's rights were protected under the basic principles of the Mental Capacity Act 2005. Documents used were of poor quality and therefore illegible at times. Decisions were not always made in people's best interests and consent to care and treatment was not appropriately sought.

New staff received a good induction to the service and training was available for staff to complete to ensure they had the skills and training to support the people living in the service, however not all staff had kept their training up to date. Evidence was not provided that registered nurses had completed suitable professional development to make sure their nursing and clinical skills were kept up to date.

Feedback from people's relatives and staff was positive about the management of the service. The management and monitoring of the quality and safety of the service needed further improvement to evidence the clear oversight of the management team.

Improvements had been made to people's care plans, they contained information that was person centred and individual. Care plans did not cover all the areas of people's care and treatment so further improvement was needed. We have made a recommendation about this.

Accidents and incidents were recorded well and monitored by the registered manager to prevent further incidents. Plans were still in place to assist people to evacuate the building or keep them safe in an emergency.

Referrals to health care professionals was evidenced however, a consistent approach was not always taken as some people were not referred for some treatments when a need had been identified. We have made a recommendation about this.

People and their relatives told us the food served was good and they had a choice. The registered manager told us people were now given a choice if they wanted to sit at a dining table to eat their meal, evidence was not provided that this was the case. We have made a recommendation about this.

People had the opportunity to discuss their wishes at the end stages of their life if they wished, however, this was not always appropriately transferred into a care plan to ensure staff understood what people wanted to happen. We have made a recommendation about this.

People and their relatives gave positive feedback about the kind and caring nature of the staff team. Staff knew people well and a friendly and more relaxed atmosphere was evident.

A greater emphasis was now placed on meaningful activity. People's interests were taken into account and catered for on a more individual basis. During this inspection, people were not left unattended for long periods of time.

Staff had a good understanding of their responsibilities in raising concerns of a safeguarding nature. Staff felt the management team would listen to and act on any concerns they had and they knew how to tell organisations outside of the service if this was necessary.

Maintenance of the premises and servicing of equipment was undertaken when necessary by the appropriate professional bodies.

The provider had continued to display the ratings from the last inspection, in August 2017 in a prominent place so that people and their visitors were able to see them.

During this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always well managed to provide a safe service.

The assessment of risk had improved although specific risks to individuals had not been considered. Potential hazards were evident around the premises. Staff did not always follow safe procedures to control the risk of infection.

Accidents and incidents were well recorded and monitored by the registered manager.

Staff were now suitably deployed to provide the care and support people required. The provider continued to follow robust recruitment practices.

The management team and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Further improvements were required to ensure people's basic rights were upheld in relation to the Mental Capacity Act 2005.

Staff did not always receive the training to make sure they had the skills and knowledge to provide the care and support people were assessed as needing. Staff had the opportunity to have one to one supervision meetings with their line manager.

Care plans were in place to provide the information required for staff to provide care and support, however, the specific care needs of some people had been overlooked.

People's nutrition and hydration were planned and catered for. People had access to advice and guidance from health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Documentary evidence was not available to show that people had been given choice about how their privacy was respected. Some people did not have access to a call bell to seek assistance when needed.

People and their relatives thought the staff were kind and caring in their approach.

The service had a more relaxed and happy atmosphere and staff knew people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's cultural needs were addressed in care planning. People and their relatives were asked what their wishes were at the end stages of their life, however, more work needed to be done to ensure a person centred approach.

More personalised care plans were now evident however daily recording by staff was not always consistent.

More opportunities were available for people to engage in activities on a daily basis.

People and their relatives knew how to complain and information was provided on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although the provider and registered manager had made improvements, further development was required to expand on this.

Quality audit systems were now more effective in identifying areas for improvement, although they had not identified the areas we found that needed further work.

Positive comments were received about the provider and registered manager from people's relatives and staff.

People, their relatives and staff were asked their views of the

service and opportunities were given to make suggestions for improvement.

Berengrove Park 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. The service had previously been rated 'Requires improvement' and we had carried out enforcement action. We returned to check if improvements had been made.

This inspection took place on 2 and 3 May 2018. The first day of the inspection was unannounced. The inspection was carried out by one inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make We also looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We observed staff interactions with people and observed care and support in communal areas. We spoke with five people who lived at the service and five relatives, to gain their views and experience of the service provided. We also spoke to the registered manager, the provider and five staff, including registered nurses, care staff and domestic staff. We requested information by email from local authority care managers and commissioners who were health and social care professionals involved in the service.

We looked at eight people's care files, medicine administration records, eight staff records including recruitment, supervision and training records, the staff rota and staff team meeting minutes. We spent time

looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Requires Improvement

Is the service safe?

Our findings

Most people were not able to articulate their views about how safe they felt living in the service. People's relatives told us they felt their loved ones were safe living at Berengrove Park Nursing Home. One relative said, "If I thought she wasn't (safe), she'd be out the door". Another relative told us the service "Felt right". Another person's relative said they thought the service was safe. They went on to explain that they felt able to say that because their loved one was previously living in another service which had now closed. The relative felt they had experienced poor care there. They said, "I can see the difference, it is lovely here".

At our last inspection, on 15 and 16 August 2017 we found that the registered provider was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The breaches were in relation to, individual risks to people's health and welfare had not been appropriately identified and reviewed; staff had not been suitably deployed throughout the home to be able to meet people's assessed care and support needs.

At this inspection we found improvements had been made to the deployment of staff around the service. Some improvements had been made to the assessment of individual risk, however, further improvements needed to be made.

Individual risk assessments had been completed by registered nurses. Standard risk assessments that identified hazards to peoples' safety when carrying out their personal and nursing care needs continued to be in place. For example, falls; pressure areas; the use of bed rails and moving and handling. However, we found that some risks that were specific to the individual were not always identified. One person sometimes displayed behaviour that staff and others may find challenging. A care plan was in place briefly describing the behaviour and advising staff to complete a behaviour chart to describe and record episodes. Staff had completed the behaviour charts. However, there was no evidence that these had been monitored by the registered manager or nurses to check if there were any recurring themes when the person became agitated, or if staff had been consistent in their approach and continued to provide appropriate support during each incident. On 1 September 2017, following an episode where the person had sworn at staff, one staff member recorded on the person's behaviour chart, 'Told [person] we do not have that behaviour here'. This approach was not included in the care plan. A risk assessment had not been completed to identify the risks associated with the person's behaviour. This would provide the guidance for staff when providing care and support to prevent potential harm to the person, other people living in the service and staff. Opportunities were lost by senior staff to analyse the documented information in order to control the risk and prevent future occurrences.

In some cases, risks to an individual had been assessed, however, suitable control measures to prevent harm had not always been identified. One person had a risk assessment in place describing 'vacant episodes'. The risk assessment briefly described the episodes and what staff should do if they occurred. A seizure chart was in place showing the person had two episodes, on 14 June and 2 August 2017. The risk assessment we saw on the day of inspection had been completed on 11 October 2017. This did not make reference to a diagnosis of epilepsy and the medicines prescribed to control the risk of seizures. The

provider sent a previous risk assessment dated 12 January 2017 to the inspector following the inspection. This risk assessment did provide the relevant information and had been updated with the change in diagnosis and treatment following the neurology appointment. However, relevant details such as the diagnosis of epilepsy, the medicines prescribed to control seizures and their known side effects had been missed off the later risk assessment completed in October 2017.

Risk assessments were in place to protect people from the risks associated with using a lap belt to prevent people falling out of their chair or wheelchair. One person had a lap belt in place to keep them safe from falling from their chair. Although the lap belt was in itself a safety measure and the reasons for use were referred to in a risk assessment, the risks associated with use, such as trapping a part of the body; twisting the belt and tightening; or trying to remove it had not been considered. One of the measures to keep the person safe advised staff they were to check on the person every half hour while sitting in the lounge with the lap belt in place, to ensure they were safe. However, there was no record made of these checks so it was not possible to monitor if the measures in place were suitable. People were not always protected by safety measures to reduce the risk of potential harm.

Health and safety hazards were visible in parts of the premises, creating a risk to people, staff and visitors. One person's call bell cord was stretched across their bedroom doorway from the point where it was plugged in across to the person's bed. This created a serious tripping risk to any person or staff member walking into the room. The person was not able to reach the call bell in order to use it as it did not reach far enough up the bed to where the person was laying. A senior care worker entered the room and removed the cord once they recognised the hazard. However, the person was left without a call bell. The person's care plan stated, 'Able to use call bell to ask staff for help'. No guidance was given to show how this could be put in place safely. A window in the first floor bathroom was broken. A piece of cardboard was covering the hole in the window with a written notice stating, 'Do not touch, broken window'. However, the notice had no date when it was put up or if the window had been reported to maintenance, so it was unclear how long the window had been broken. The cardboard was not secured, so the hole in the window was easily accessible, creating a clear hazard of potential injury. A first floor corridor leading to a set of stairs and a communal bathroom was dark throughout the two days of inspection as the light was not turned on and there was no natural daylight entering the corridor. We checked the light switch and it was working. The corridor was sloped downhill slightly and a hoist was standing in the middle of the corridor through the duration of the inspection. The situation created a serious risk of people, staff or visitors falling over the hoist or tripping in the dark.

The sluice room and the laundry room each had a notice on the door stating, 'Keep door locked at all times'. This was to ensure people could not gain access, placing them at risk of potential harm due to equipment and detergents that may be used. However, both doors were unlocked and the laundry room door did not have a lock in place. This meant people and visitors were placed at risk of injuring themselves or ingesting harmful substances.

Staff did not always evidence that they fully understood the risks associated with cross infection. A staff member took a tray of hot drinks around people's bedrooms. They put the tray down in each room on a flat surface, such as a chest of drawers, to remove a cup to give to the person in the room. The staff member then picked the tray up and moved on to the next room. This created a risk of cross contamination between people. Laundering people's clothes was not managed well. The laundry room was not well organised, we saw clothes and underwear in one basket, some labelled with names and some without. Soiled clothing was lying on the floor when we stepped into the laundry room. The area was generally unclean. We found that not all underwear and clothing was labelled with people's names. This meant that people had some underwear and clothing in their drawers and cupboards that did not belong to them. The paint and

laminate was peeling off the sink vanity unit in one bedroom. Staff used the sink to wash their hands and access water to wash people. This created a risk of infection as it would not have been possible to clean the sink unit to a suitable standard.

The failure to ensure people receive care that is safe is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their prescribed medicines safely. Prescribed creams were kept in people's bedrooms so staff could access them when providing personal care, to apply as prescribed. We found creams in people's wardrobes, personal drawers, cupboards and shelves that were out of date. One person had a cream in their room with an expiry date of February 2018 and another cream where the label had been removed. This meant people were at risk of using creams that had lost their efficacy or were harmful and using creams that were not prescribed for them. Some creams had the lids off and some had labels missing. One person had four large tubs of the same cream, all were open and the date of opening was not written on the label. This meant it would not have been possible to know which had been opened first to enable staff to use them in date order to make sure they did not reach the expiry date. Another person had a large pump dispenser of E45 cream lying on its side inside their wardrobe with the lid off. The date of opening was not written on the label. The cream was dispensed in September 2016 and was due to expire in June 2018. This posed a risk of cross contamination as the cream was exposed to various contaminants within the wardrobe. A smaller tub of E45 cream was also kept in the wardrobe and we were unable to read the date on the dispensed label as it had worn away. This meant prescribed creams may be used when the expiry date had passed. There was no evidence that stock checks of prescribed creams had been kept to ensure stock was in date, administered and stored correctly.

One person's medicines care plan stated they often refused their medicines, however no guidance was given for nurses to follow if this happened or how to support and encourage the person in these circumstances. A risk assessment had not been completed to highlight the risks to the person of not taking their medicines and what measures the nurses should take to reduce harm.

Some people were prescribed 'as and when necessary' (PRN) medicines. This meant people could ask for the medicine if they needed it. No guidance or procedure was in place for nurses to follow to ensure the medicines were administered safely. For example, one person was prescribed Paracetamol PRN. Although they had not asked for or been given the medicines since the current medicines administration record (MAR) was commenced, on 23 April 2018, the person had been administered the medicine on the morning of our inspection. No entry was made on the reverse of the MAR to show the reason for administering the Paracetamol that day. This meant nurses may not be able to monitor the person's pain, if they did not know the reason they required the medicine previously. A pain assessment tool was not used to assist nurses in determining whether a person who was not able to verbally communicate their pain level may be in pain before administering painkiller medicines. We asked a nurse about this and they said they did not use a tool as they could tell by a person's facial expressions. This is not a reliable method for safely determining if a person is in pain and would not assist a new or agency nurse who did not know people well. People were at risk of not receiving their medicines as prescribed or for the purpose intended.

Thickener powders are used as part of the treatment of people with dysphagia (swallowing problems). The thickening powder is added to foods and liquids to bring them to the right consistency/texture so they can be safely swallowed to provide the required nutrition and hydration. Thickener powders must be stored safely and appropriately as incidents have been reported where harm has been caused by the accidental swallowing of the powder when it had not been properly stored out of reach. We asked a nurse where the thickener was stored and how many people had been assessed as requiring thickener in their drinks to

prevent choking. The nurse said the thickener powder was always kept locked in the medicines trolley. We were told five people required thickener and that one person had four scoops of powder and the other four people had two scoops of powder. We checked the medicines trolleys and found only two tubs of thickener. We asked a nurse if this meant people shared the tubs and were told, "I think they do". A care staff member then arrived in the clinical room to ask for a tub of thickener to take downstairs for the tea trolley. The registered nurse told the staff member they would bring it down later. This showed that thickener powder may not be used as prescribed as tubs were used communally. The prescription label for each individual, with the amount prescribed, was not accessible to the staff using it to ensure they used the correct amount. People were at risk of ingesting the powder which could be harmful to their health as the thickener powder was placed on an open accessible tea trolley.

Medicines audits were not effective. Regular counting of medicines was not carried out to check if the correct numbers of medicines in stock tallied with the amounts used, to check for errors or irregularities. One person was diabetic and prescribed Lantus Solostar insulin injections. Although the entry for the prescribed medicine was made on the MAR and signed for by the nurses, the amount of the medicine in stock was not entered or carried forward so there was no evidence of how much of the medicine was in stock in the service. Another person was prescribed Laxido one or two sachets PRN. The person had been given the medicine for the previous four days. The amount given, either one or two sachets, was not recorded on the MAR. We checked the amount left in the box and only 10 out of 28 sachets were left. As the amount of sachets carried forward from previously had not been recorded on the MAR, there was no way of ascertaining how many had been administered over the four days. This meant people may be administered too many medicines or not enough with no way of the registered manager or nurses knowing if errors had been made and people had been placed at risk of harm.

The clinical area and some equipment was not kept clean. A suction machine was unclean and condensation within the machine was a concern. One person who had diabetes used an insulin pen. The pen was encrusted with a substance that had evidently been there for some time. The insulin pen was labelled with a tape and dated 3 April 2018, but no name to identify the user.

The failure to ensure consistent safe management of prescribed medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were documented by staff and the registered manager checked the correct action had been taken, carrying out an investigation where necessary. The registered manager conducted an analysis of all accidents and incidents through the month, checking for themes and concerns. They documented the action taken and if further action or follow up was required, such as a referral to a healthcare professional, discussion at staff meetings or individual discussion with staff in supervision meetings.

Some people needed staff to use a hoist to help them to move from one area to another, such as from their bed to a chair. Clear guidance was in place for staff so they knew which size and type of hoist sling was needed to protect people from being harmed when being moved with hoisting equipment.

Where people had sore areas on their skin, nurses had kept records of treatment given and the progress of healing. Written records and photographs showed the progress of wounds and meant healthcare professionals could be given accurate information to provide appropriate advice.

Staff had a good understanding of their responsibility to protect people from abuse. The guidance and advice staff would refer to about abuse if they had a concern to report was available through a safeguarding

procedure. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us they would have no problem raising any worries they had with the provider or registered manager and they were aware of who to contact outside of the organisation should this be necessary. Safeguarding referrals had been made to the local authority by the registered manager and the provider when necessary. Safeguarding incidents had been investigated and recorded appropriately.

All the relevant maintenance and regular servicing checks were carried out by appropriate contractors and all were up to date. For example, gas safety, electrical installation safety, portable electrical appliances safety and legionella testing. All fire records were complete, those carried out by contracted engineers and weekly or monthly testing carried out by staff. Personal emergency evacuation plans (PEEP's) were in place for each person. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. Handwritten additions had been made to some PEEP's when people's circumstances had changed and regular reviews were carried out to ensure they were up to date, although the additions were not always easy to read. We spoke to the nurse responsible for keeping PEEP's up to date. The nurse said they would ensure all additions were typed up so that records were easily read.

Robust recruitment processes continued to be carried out by the provider. The appropriate checks were made to ensure only suitable staff were employed to support people living at the service. Applicants completed an application form and were asked to provide a full employment history. Interviews were held to assess their suitability and aid the decision making process. References were followed up and checks had been made against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working people who needed safeguarding. Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their PIN numbers to confirm their registration status.

Requires Improvement

Is the service effective?

Our findings

We asked people if staff had the skills to provide their care and support. Only some people were able to give us their views verbally. One person did tell us, "The staff are very, very good" and "Anyone who is not so good, is not here for long".

At our last inspection, on 15 and 16 August 2017 we made two recommendations for improvement to the provider and registered manager in relation to, familiarising themselves with the Mental Capacity Act 2005 (MCA 2005) and the associated Deprivation of Liberty Safeguards (DoLS) to ensure ongoing compliance with the principles of the Act and creating opportunities for people to choose different options for their dining experience.

At this inspection, we found that an understanding of the MCA 2005 was lacking in many areas. Although we were told people were given the choice to sit at the dining tables and people had chosen not to, we found no evidence of these discussions.

At the last inspection, in August 2017, we made a recommendation to the provider and registered manager to familiarise themselves more fully with the principles of the MCA 2005. This was because we found people had lap belts in place when sitting in wheelchairs. A mental capacity assessment had not been undertaken and a best interests process had not been followed. This was required as a lap belt could constitute a form of restraint if the person did not have the capacity to consent to the safety measure. At this inspection, we found the provider had sent a letter to the relevant people and their family members to explain the need to use a lap belt for safety purposes and requesting their consent. Where people had been assessed as lacking capacity to consent to a lap belt being used while sitting in a chair or wheelchair, people's family members signed their consent. However, it was not always clear if the family member signing the consent had the legal right to do so. One person's family member had signed their consent to use a lap belt. However, there was no record or evidence that they held a Lasting Power of Attorney (LPA) for health and welfare decisions. This would give them the legal right to make decisions around care and treatment on the person's behalf. Another person who had a lap belt on their wheelchair had been assessed as having the capacity to make this decision. However, another person had signed the person's consent form and it was unclear who had given their consent, as a name was not written to identify the person. This meant people may be denied their rights to give or withhold their consent to care and treatment. The registered manager had not attended any further training since the last inspection, in August 2017, to ensure they had a sound knowledge of the MCA 2005. This meant the evidence was not available to show the registered manager had taken steps to ensure they had the knowledge necessary to uphold people's rights under the basic principles of the MCA 2005.

The Mental Capacity Act 2005 (MCA 2005) 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. Some improvements had been made in regard to supporting people's rights within

the basic principles of the MCA 2005. Assessments had been completed to check if people had the mental capacity to make particular decisions about their care and treatment. One person needed to have rails on their bed to protect them from harming themselves by falling or climbing out of bed. A mental capacity assessment had been completed to check their capacity to make the decision to have bed rails in place. However, the mental capacity assessment forms being used were such poor copies that the text was illegible. The questions asked on the form that staff responded to in order to assess people's capacity were a blur of ink. This meant staff could not be sure they were answering all questions appropriately as they could not read the questions.

Although mental capacity assessments were in place, staff had not taken a best interests approach in some areas of decision making. One person had been assessed to determine whether they had the capacity to consent to staff providing their personal care, such as washing. The person was assessed as not having the capacity to consent to the care required. The member of staff completing the assessment recorded, 'No-one has stated that [Person's name] should not be washed'. No further record was made regarding why it was necessary the person had help with their personal care needs, when the decision was made and who had been involved in making the decision on the person's behalf. The person's assessment also stated, 'Nursed in bed by choice as his shouting causes altercation with other residents'. The person's mental capacity assessment stated they did not have the mental capacity to make this decision. No evidence was provided to show how the decision had been made that the person was nursed in bed for the reason given. The person's communication care plan recorded, 'shouts out and calls for help'. Clear guidance was not given how to support the person appropriately to prevent their need to call for help regularly. We heard the person shouting out and calling for help many times through the day. They did not have access to a call bell. We were told having a call bell made the person more anxious so staff did not give them access to the call bell as this helped to reduce their anxiety. However, this was not recorded in the care plan and had not been appropriately discussed and recorded as a decision taken in the person's best interests. We spoke to the person who told us they liked to leave the door to their room open so they can see people and staff walking by. Few people passed the room as it was away from the main part of the building, however was in close proximity to the provider's office so they regularly stopped to chat. This meant people's views and previous history were not taken into account when decisions were made on their behalf.

The failure to demonstrate that people's rights had been considered according to the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and nursing staff had carried out mental capacity assessments with people to determine if they were able to understand and retain the information necessary to consent to their care and support. Where people were found to have lacked the capacity to make this decision the registered manager had made the appropriate DoLS applications to the local supervising authority.

Staff were able to describe how they gave people choice and time to make their own decisions. One staff member described how they supported one person to socialise with other people in the communal lounge. The person did not usually want to go into the communal lounge and always said they wanted to stay in their room. The staff member told us how they gave positive encouragement each day to try to prevent social isolation. The person went into the lounge approximately once or twice a week, sometimes only for 20

minutes and sometimes may stay the whole day. The person could always return to their room whenever they wished and the staff member told us they ensured they were aware of this at all times.

Staff received suitable training to have the confidence and skills to undertake their role. Most training was through a range of DVD's to watch and learn, followed by a written assessment to test their knowledge. Completed assessments were sent away for independent marking. One of the senior nurses took responsibility for training and making sure staff were up to date with their regular refresh updates. However, we found that some staff had not kept their training up to date. Out of 22 staff, 10 had not completed either the theory or practical moving and handling training; six staff had not completed fire safety training and six staff had not completed first aid training. One member of staff told us, "I like the training by DVD as there is lots of information and you can stop and start when you want to suit yourself. I can refresh over my notes when I like".

Nursing staff supported each other through the revalidation process with the Nursing and Midwifery Council (NMC). The NMC sets standards of education, training and performance so that nurses can deliver high quality healthcare. The provider had not always provided sufficient training for registered nurses to ensure their skills were updated and their professional development continued. We saw that registered nurses completed the same DVD training as care staff. However, many nurses had not kept up to date with this basic training either. Out of eight registered nurses, including the registered manager, five had not completed fire safety training; five had not completed continence care or tissue viability training; four had not completed MCA 2005 and DoLS training; four had not completed dementia care training, despite providing nursing care to a number of people living with dementia; four had not completed challenging behaviour training, despite providing nursing care to people whose behaviour may at times challenge others; three had not completed first aid training; two had not completed safeguarding vulnerable adults training; two nurses had not completed moving and handling training. There was little evidence of further clinically based training to provide professional development. One nurse had taken part in diabetes training and a palliative care training day was planned for June 2018. Nurses told us they had completed training with external nursing agencies, however, they did not have certificates to evidence this. The lack of basic training for some nurses and the lack of continued professional development meant nurses may not be equipped with the skills and knowledge required to carry out the role they had trained for.

Although nurses received supervision, these one to one meetings were not clinically based to ensure their personal development was in line with their professional role and to ensure their practice continued to be of the standard expected by their profession.

The failure to demonstrate that staff had received the training and development required to provide the care and support people were assessed as needing is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received an induction to make sure they had the knowledge and confidence to carry out their new role before being signed off to work alone. Staff told us a period of shadowing more experienced senior support staff members followed initial training.

Staff continued to receive support through one to one supervision meetings with their line manager. Supervision meetings give staff the opportunity to receive feedback of their performance and to discuss support required to improve such as extra training. Staff can also raise issues that may affect their performance such as personal or domestic concerns. Staff confirmed they regularly met with their line manager and had the opportunity to discuss concerns as well as their own development. Staff told us they felt confident to ask for advice and help at any time from the registered manager, the provider or the nurses.

One staff member said, "We can be open and honest, even if it seems irrelevant – they never say they don't have time".

Although some aspects of daily recording had improved, such as how staff reported on their personal interaction with people when providing their daily care, daily recording charts had not always been completed by staff. The charts used to record when people had a bowel movement had not been documented regularly by staff. One person's bowel chart had not been completed since 27 April 2018 up to the day of inspection on 2 May 2018. No records were made to suggest this had been investigated as a health concern or whether it was poor staff record keeping. This meant people were at risk of being constipated and not receiving appropriate treatment or that people may be given medicines to treat constipation when this was not required. People who were nursed in bed needed staff to change their position regularly to prevent them getting sore pressure areas on their skin. Staff were expected to record on the person's positional change chart when they had helped the person to move position, recording which side they had moved them to. The charts were not always completed consistently. One person's chart showed they were placed on their back each time they were moved. Nurses took the blood pressure of one person every month and in December 2017 their blood pressure was low. The nurse recorded that staff were to encourage fluids. There was no record that the blood pressure was checked again or that the GP had been contacted for advice. The same person's blood pressure was unusually high in March 2018 and no indication of the elevation was documented or if any action was taken. We asked a nurse about this who could not give an explanation or tell us what the normal procedure would be when people's blood pressure was unusually high or low. The person's blood pressure was not recorded in April 2018. People may not receive the appropriate treatment to ensure their health is maintained due to inconsistent recording and monitoring.

Nurses had completed a range of care plans to support staff to provide the care people had been assessed as needing. Improvements had been to the care plans since the last inspection in August 2017 to provide a more holistic approach to people's needs. Each care plan showed how to support people including, personal care; tissue viability; oral health; social interests and hobbies; administration of medicines; pain and continence. Not all care plans were completed fully or provided the information required to meet people's wishes. One person had a foot care plan which guided staff to encourage the person to 'Move [their] legs as much as tolerated'. However, the person's legs were contracted which meant they were unable to straighten their legs and they could be painful to move. No guidance was given to staff through the care plan how to encourage movement safely and without causing further pain. Where people had care needs other than the areas covered in every person's care plans above, these were not always taken into consideration to develop a specific and personal care plan. We found references to one person having 'vacant episodes' through a risk assessment and referred to in records of contact with health care professionals. However, a care plan had not been developed to provide the specific guidance and advice to staff to enable them to support the person in the most appropriate way to meet their needs.

We recommend the provider and registered manager seek guidance from a reputable source to ensure the staff developing care plans have the necessary skills.

A relative told us, "If they (Staff) think [Relative] needs a GP, they automatically call" and "If there is anything wrong, they call me". People living in the service had complex health needs that needed the expertise of registered nurses to ensure their needs were met. Nurses continued to keep records of referrals to and visits by health care professionals. Records were made of visits and telephone calls by the GP and visits by the dietician, district nurses, opticians and dentists. However, some people's care plans recorded when they had recently moved in to the service they were to be referred to a chiropodist or dentist. We found that evidence was not available to show this had actually happened for some people. This meant that some

people may not have access to all the health care advice and treatment they required.

One person told us the food was "Very good. It's part of your life". People had two meal options to choose from the daily menu. A relative told us they often assisted their loved one to eat their meals as they visited at lunchtime. They told us their loved one had a 'special bond' with a member of staff who could always encourage the person to eat their meal if they were reluctant. People who had been advised by a health care professional to adhere to a special diet were catered for and the cook was aware of each person's requirements. At the last inspection, in August 2017, we made a recommendation that the provider and registered manager look at ways to create opportunities for people to choose different options for their dining experience. This was because we had found that no people sat at a dining table to eat their meal. At this inspection we saw that people living in the service continued to not eat their meal at a dining table. We were told again people had been given the choice whether to eat at a dining table or on a lap table in front of their lounge chair or in their room. We again found no evidence from people's records that people had been given a choice or were encouraged to move into a different area of the home to eat their meal and supported to socialise over their food.

We recommend the provider and registered manager seek ways to ensure people have access to dining options at mealtimes by gaining advice and guidance from a recognised source how to offer meaningful choice.

Requires Improvement

Is the service caring?

Our findings

Few people could articulate their views about the caring attitude of staff. One person told us the staff were, "Very good girls, they work hard. I like it here". Relatives had only positive things to say about the staff and how their loved ones were treated. One relative said, "They (staff) cuddle her and treat her like family". Another relative told us, "They (staff) get her up every day if she wants to". The relative told us that sometimes their loved one didn't always want to get up and prefers to stay in bed. The relative was pleased their loved one had that option. Another relative commented, "Nothing is a problem and never has been. They're willing to help and do whatever's necessary" and, "What I like is that even the cleaners come in and talk. They may not get a response but they will talk".

At our last inspection, on 15 and 16 August 2017, we found that the registered provider was in breach of Regulations 9 and 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The breaches were in relation to, the failure to meet the needs and preferences of people living in the service and not ensuring people's privacy and dignity were respected by the provision of appropriate window coverings where preferred.

At this inspection, we found that improvements had been made to meeting people's needs and preferences although further improvement was needed. The provider told us that since the last inspection people living in the downstairs front bedrooms had been given a choice regarding the window coverings in their room. However, we did not find clear evidence of this.

At the last inspection in August 2017, we raised a concern around the ground floor bedrooms not having window coverings such as nets or blinds in place which may mean people's privacy was not respected. We found at this inspection that staff had made contact with some people's family members to ask if they would like their loved one to have nets at their bedroom window. One person's family member told staff in October 2017 they did not want their loved one to have nets to cover their window. However, a mental capacity assessment had not been completed to check if the person was able to make this decision themselves. There was no record of any further discussion about this to show the person's best interests had been taken into account, for example, establishing if the person had chosen not to have window coverings such as nets or blinds at their windows through their life. Or whether they had always had window coverings to protect their privacy. This information would have supported the process of ensuring the decision made was in the person's best interests. We asked the registered manager if there was any further documentation to evidence the process taken and we were told there were no further records. This meant although the registered manager had told us people had been given choice, there was limited documentary evidence to support this was the case.

Some people did not have access to a call bell in order to call for staff help if they were needed. We saw three people nursed in bed or who stayed in their bedroom who did not have a call bell near to them to summon help. It was not recorded in the care plan or a risk assessment for these three people that they were unable to use a call bell and therefore other arrangements were in place to make sure they were safe. One person had a risk assessment in place dated 16 March 2017 stating because they were registered as

blind they could not use the call bell 'effectively'. However, the monthly review of the risk assessment on 28 August 2017 stated the 'call bell in reach at all times'. A mental capacity assessment was in place recording that the person was unable to use the call bell. Care staff were not consistent in their daily recording whether a call bell was used by the person. Over a period of one week's records from 18 April to 25 April 2018 only one record described the call bell had been left in place. The inconsistency of care planning records meant the person may not get the care they required every day.

We recommend the provider and registered manager seek professional advice in order to ensure all people living in the service can readily access the call bell system.

At tea and coffee times on the first day of inspection, drinks were carried around on a tray already made up in plastic beakers with lids and given to people. Staff did not ask what each person wanted to drink or if they wanted milk or sugar in their drink. We later asked a member of staff if this was how drinks were offered to people usually. They told us this should not have happened; a drinks trolley should always be taken to each person to give them a choice of drinks. We saw a drinks trolley in use at other times.

Staff were more present around the service, attending to people's needs and chatting to people. Although there continued to be times when people were alone in the lounge with no staff or activities personnel present, there was a clear improvement since the last inspection in August 2017.

One person had their birthday on the day of inspection. Staff had put up balloons around their bed and birthday cards were in place on their trolley table. The person's family were coming in that afternoon to eat birthday cake, made by the kitchen staff. Their relative told us the kitchen staff always made cake for every person's birthday.

Staff knew people well and were able to describe their individual needs and wishes. One staff member told us about one person who they always made sure was not seated too near other people as they did not like to be 'crowded' or touched. The staff member said, "You have to know people really well and be instantly prepared". A relative said, "They can't really do enough for us".

Requires Improvement

Is the service responsive?

Our findings

Few people could tell us if they had enough opportunity to socially interact with others and to meet their interests. We observed the planned activities on offer during the inspection and noted some people who were actively participating in an exercise to music session with an external co-ordinator. People were completing the exercises and singing along to the music with the encouragement of the coordinator. The external co-ordinator commented to people that they were, "On fire" when taking part in the exercises. One person replied, "We sure are kid".

At our last inspection, on 15 and 16 August 2017, we found that the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The breach was in relation to the failure to meet all the individual needs and preferences of people living in the service.

At this inspection, we found improvements had been made to meeting the individual needs and preferences of people, however this work continued to be in progress so further improvement was needed.

Activities and staff engagement with people had improved since the last inspection in August 2017. The provider had introduced more external activity providers to the service who provided group sessions in the communal lounge area three days a week. These consisted of music, movement and exercises. Further external entertainment was provided at other times across the period of each month. Two members of staff provided activities each weekday afternoon and some weekends between them. This was an additional role to their usual positions within the service. They encouraged people to get involved in activities such as quizzes and word and memory games as a group within the communal lounge. However, they concentrated mainly on providing one to one sessions with people in their bedrooms, for example reading, painting, puzzles or pampering sessions such as nail painting and hand massage. In recent months, an 'Easter tea' had been organised where people's families and staff families were invited. Photographs showed people wearing Easter bonnets. A local children's nursery had visited at another time to spend time with people. The provider told us this had been very successful and photographs were available to evidence this. Another visit was planned with a view to the engagement with the children's nursery becoming a regular event. Although records to evidence people's involvement in either group or one to one sessions had improved, we found this to be an area for further improvement as these were not consistent.

People's interests, and hobbies if they had one, were recorded in their care plan to enable staff to plan to spend more quality time with people. One person who was nursed in bed enjoyed watching the television and their favourite programmes were listed in their care plan. This meant staff were able to ensure these programmes were on for the person to watch. Staff told us activities and activity plans were much better and had improved significantly since the last inspection in August 2017. Staff told us they were now doing more with people and had more time in the afternoons to spend time with individuals having a chat. One member of staff said, "That is a great part of the job".

One external activities provider was encouraging people to take part in the session of exercising to music. People took time to become engaged but with patience the activities provider had supported people to join

and people were enjoying themselves very quickly. The organiser obviously knew people well to be able to respond individually to people's needs. One person was singing and clapping and completing all the exercises. Another person said it was, "Jolly good".

People's religious and cultural needs had been considered through care planning. One person's care plan showed they were a Roman Catholic but had chosen through their life not to practice by attending religious ceremonies. Their care plan stated however that staff must arrange a local priest to visit if this was requested by the person or their family member at any time. One person told us a priest visits them regularly and said, "He gives me Holy Communion".

At the last inspection, in August 2017, we reported that two separate care files were in use, one for the use of registered nurses and one for care staff to use. At that inspection, we found very little information in the care file used by staff to enable them to provide the necessary care and support to meet people's needs. At this inspection, two care plan files continued to be in use, however, the information provided in the care plan file used by staff had improved. The information now included a life history which in most cases was well written and provided a detailed insight into the person, their life and the people who were important to them. However, one person was registered as blind and although a care plan was in place with guidance for staff to aid their communication with the person, this was in the nurse's care file. There was no evidence the person had been referred to an organisation specialising in supporting people with sight impairment who could advise on resources available to provide extra support to the person. The life history in the care staff file made no mention of the person's sight impairment which had occurred in recent years. However, a staff member had purchased some talking books which the staff had documented had been a success and the staff member was therefore going to get some more. Staff recorded an account of their contact with people each time they provided personal care or spent time chatting to people. The provider and registered manager had developed a new daily record to support staff with their time management by having a tick box to record some tasks undertaken. This supported staff requests to cut down on the amount of writing they needed to complete. This had worked well in many instances but staff had not always completed the tick boxes appropriately. One person who had many of their own teeth needed support to brush their teeth each day. Over the period of one week we saw that staff had only made a recording on one day that they had supported the person to brush their teeth. We looked at another person's daily records which showed a more consistent approach to recording the support given with teeth cleaning. Although daily record keeping had improved since the last inspection in August 2017, we found this to be an area that needed further improvement and a more consistent approach.

People, and their relatives where appropriate had been involved in planning their care and now signed their care plan to show this was the case.

People did not have specific end of life care plans but did have an 'advanced directives' care plan to record people's wishes when they were nearing the end of their life. These were not always written using a person centred approach and were therefore lacking in individual detail and information. One person's advanced directives care plan stated '[Name] is elderly and will eventually deteriorate and die'. The care plan did not specify what the person's current situation was, although other areas of the care plan suggested they had been improving.

We recommend the provider and registered manager seek advice from a recognised source to further enhance the care plans in place to support people with their preferences and wishes for the end of their life.

People's relatives knew who to contact if they did have any complaints or concerns. One relative said, "I would speak to [The provider] or [The registered manager] with any concerns". Another relative commented,

"I've never had anything to complain about". No complaints had been made since the last inspection in August 2017. A complaints procedure continued to be in place with the information required to enable people or visitors to make a complaint if they needed to. The provider had improved the procedure by including the details of the Local Government Ombudsman (LGO) if people or their relatives were not happy with the way their complaint had been handled.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us they thought the service was well run. One relative commented, "Since I met (The provider), she gave me confidence, she was in charge and on top of it". Another relative said, "They are all very approachable".

At our last inspection, on 15 and 16 August 2017, we found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to the failure to ensure the systems in place to regularly assess and monitor the quality of the service were used effectively to take action to make the required improvements. We also made two recommendations for improvement to the provider and registered manager in relation to, seeking guidance from a suitable source of providing effective supervision to support the role of the registered manager and to seek to develop an effective system of staff team support.

At this inspection, we found that improvements had been made and the systems in place to check the quality and safety of the service were used more effectively. As seen through this report, further work was needed to ensure people received a service of good quality and safety.

The registered manager had a range of auditing processes in place to monitor the quality and safety of the service provided. Monthly audits included, pressure ulcers and skin tears; infection control; kitchen and catering, care plans, cleaning and environment; medicines; health and safety; accidents and incidents.

Each monthly audit showed where concerns and areas for improvement were identified, the action needed to be taken and the date the action was completed by. However, some audits had not been effective as we found areas that required action which had not been identified through the provider's monitoring process. We found the nurses suction machine was unclean and a bedroom sink vanity unit was grubby with peeling paint. The infection control audit had not identified these areas as being a hazard. We found areas of medicines management that required improvement and these had not been picked up during the monthly medicines audit or at any other time. For example, there was no PRN guidance in place, nurses had not been counting the medicines to ensure the correct numbers were in stock and there were concerns around the management of people's prescribed creams and thickeners. Audits of people's care plans were detailed and showed where many areas for improvement had been identified, an action plan was in place and actions were monitored by the registered manager until they had been completed. Although this was the case, we found areas of care planning that were not complete such as individual risk assessments.

Names were not shown on bedroom doors or within the room to make it clear who was living in the room. This meant that administering medicines could cause confusion for new or agency staff if people were not able to confirm their identity. Shared rooms were in use. There was nothing in place to easily identify which person was which within each room. Folders containing peoples' daily charts were placed within each room, however, both charts were often placed together on a chest of drawers. No photographs were evident on many of the daily folders so it was impossible to identify which person the charts belonged to if a new or agency member of staff was on duty. As prescribed creams signing charts and individual food and fluid and

position change charts were in place, it was crucial the correct person was identified.

The failure to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had not held meetings with people who lived at the service to ask their views and opinions and to be able to share relevant information, a record had been kept of a discussion regarding the choice of a new wallpaper for the hallway and stairs. The provider sought feedback from people's relatives. One meeting had been held since the last inspection in August 2017 where the provider fed back to relatives the ratings and content of the CQC report that had been published following that inspection. The records of the meeting showed relatives had shown their positive support of the provider, the registered manager and the staff. People's relatives told us about the meetings and how they were given information and kept up to date. One relative told us how they had become acquainted with other relatives as a result. The provider carried out an annual survey, asking people, their relatives and others involved in the service such as health and social care professionals, their views. As the survey was usually sent out in June each year, none had been undertaken since the last inspection in August 2017.

Staff meetings were held regularly and were attended by both the provider and the registered manager. The records kept of staff meetings were basic and minimal so it was difficult to ascertain the level of interaction taking place with staff and if staff had the opportunity to raise their own issues and concerns. However, staff confirmed meetings were regularly held and also told us they were able to raise suggestions or concerns and these were listened to.

Staff told us they thought many improvements had been made since the last inspection in August 2017. One member of staff said, "A lot has been changed for the better. For example, daily records and checks are much easier now as the paperwork has changed. We now know what is expected of us regarding writing and recording". Another member of staff said, "It is still a work in progress but we are improving". Staff continued to have positive views about the running of the service. The comments we received from staff included, "All the management team and the nurses are approachable at any time"; "I think the home is well run and organised"
and, "We have good team-working".

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths without delay. Notifications had been received by CQC about important events that had occurred since 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 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to demonstrate that people's rights had been considered according to the basic principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure people received safe care and treatment. The provider and registered manager failed to ensure people received their prescribed medicines in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to demonstrate that staff had received the training and development required to provide the care and support people were assessed as

needing.