

Allenbrook Nursing Home Limited

Allenbrook Nursing Home Limited

Inspection report

209 Spies Lane
Halesowen
West Midlands
B62 9SJ

Tel: 01214225844
Website: www.allenbrooknursinghome.co.uk

Date of inspection visit:
01 November 2017
02 November 2017

Date of publication:
02 February 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 01 and 02 November 2017 and was unannounced. At our last inspection in April 2016, we found the provider was meeting the regulations however the service was rated 'Requires improvement' overall. At this inspection, improvements had not been made. The provider continued to be rated as 'Requires improvement' overall and we identified four breaches of the regulations.

Allenbrook Nursing Home is a care home with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 36 people in one adapted building. At the time of our inspection, 25 people were living at Allenbrook Nursing Home.

There was a registered manager for this service who had registered in March 2017. 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. At the time of the inspection, the registered manager was on planned leave. An acting manager had joined the service in August 2017 and was present throughout our inspection.

People and relatives told us they felt the home was safe however safeguarding processes failed to consistently protect people and ensure concerns were always dealt with openly. Staff were not always aware of their responsibilities in this area. Incidents had not always been reviewed and escalated as required to the Commission and relevant partner agencies. Before our inspection, the local authority safeguarding team informed us of a past allegation of sexual abuse involving a service user. We prompted the provider to inform the police of this allegation and we are continuing to consider our regulatory response to this information.

Staff showed some awareness of how to manage some people's risks however risks were not always monitored and managed effectively. Improvements had been made and were still ongoing to ensure people were always safely supported with their medicines.

We received mixed feedback as to whether there were always enough staff on duty and found staffing levels did not always help meet people's individual needs. Recruitment checks had been undertaken to assess the suitability of staff however the provider had not renewed some checks as planned.

People, and relatives, expressed satisfaction with the support provided. We saw some positive examples of support however this was not consistent, for example around dementia care. People were supported with basic decisions about their care although assessments had not always ensured people could always be supported to make their own decisions as far as possible. Staff were not always aware of the Mental Capacity Act (2005) although they had received training in this area. Staff felt more supported since the

acting manager had joined the team and training gaps were being addressed.

People had improved access to drinks to remain hydrated and gave positive feedback about food at the home. People's healthcare needs were not always monitored as often as planned to help always identify any changes or concerns promptly. People were supported to access healthcare services however the provider intended to improve partnership working as referral systems had not always been effective. Care had been taken to ensure the design and decoration of the home was developed around some people's preferences, although this had not always been achieved for all people and in response to the needs of people living with dementia.

We saw some caring practice and found some people and staff had positive relationships. This was however, not always consistent and we found less independent people were not often approached and engaged. Improvements were still required around how some people's communication needs were met. Although people were often treated with dignity and respect, this was compromised at times by some task-based approaches to care.

People's care was not always planned and delivered to always meet their needs as far as possible. The provider did not always take reasonable steps to gather and keep under review, people's end-of-life wishes. Care was taken to meet people's cultural and religious needs and we saw some people had good access to activities, however this was not consistent. People felt able to raise complaints however improvements were required to ensure complaints were always addressed and used to drive improvements.

The provider had failed to always uphold their responsibilities to the Commission and ensure safeguarding matters and other notifiable events were shared with us and partner agencies as required. The provider had not maintained sufficient oversight to always support the work of the management team and ensure a good quality of care was sustained. Quality assurance processes had not always identified safety concerns and quality issues. People and relatives expressed satisfaction with the service provided. Systems and processes did not ensure all staff always had access to current information about people's needs and preferences through effective record keeping.

This is the third time the service has been rated Requires improvement overall. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Staff knowledge and safeguarding systems did not consistently protect people from abuse. Some systems were followed to help monitor people's risks although this practice was not consistent.

Reasonable steps were not taken to learn from and address incidents and errors to help promote people's safety.

We saw that people were supported to take their medicines safely, however further improvements were required to ensure consistently safe practice.

Staffing levels were not always sufficient to meet all people's needs. Staff recruitment checks had helped assess the suitability of staff although some checks had not been renewed as planned.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People provided positive feedback about their support, however all people's needs were not always met, for example around dementia care. Staff had received some training and guidance for their role and reported an improved experience since the acting manager had joined.

People were supported to make basic decisions about their care. Some improvements were underway in this area and we found that staff were not always familiar with the MCA.

People had access to healthcare support. The provider intended to improve partnership working with healthcare professionals as referral systems had not always been effective.

People were supported to eat and drink enough to maintain a balanced diet of their choice. Improvements were required however to ensure people's health needs were effectively monitored and responded to, and their health always promoted, as far as possible.

Is the service caring?

The service was not consistently caring.

We saw some caring practice and people were often treated with dignity and respect, however this was compromised at times due to a task-based approach from some staff.

People had some opportunities to get involved in their care and told us staff were kind.

Requires Improvement 

Is the service responsive?

The service was not consistently responsive to people's needs.

People were supported with appropriate end-of-life care at the time of our inspection, however systems had not ensured this practice was always consistent.

People's care planning and delivery was not consistently person-centred. Improvements were required around how people's needs associated with dementia were met. We saw some people had good access to activities however this was not consistent. Care was taken to meet people's cultural and religious needs.

Improvements were required to ensure complaints were always addressed and used to drive improvements to the quality of the service.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

The provider had not maintained sufficient oversight to always support the work of the management team and ensure good quality care was sustained. Quality assurance processes had not always identified safety concerns and quality issues.

Systems and processes failed to ensure and drive improvements to the quality and safety of the care and support provided to people, and to ensure records were suitably maintained and accessible. The provider failed to uphold all of their responsibilities to the Commission.

Requires Improvement 

Allenbrook Nursing Home Limited

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 checked 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 inspection was prompted in part by our intelligence held about the provider. Shortly before our inspection, we were also informed by the local authority safeguarding team of a past allegation of sexual abuse. We ensured this incident was shared with third parties including the police for further consideration and as a result this inspection did not examine the circumstances of the incident. The information shared with CQC about the incident indicated potential concerns about the management of risk of abuse towards people living at the home. We examined those risks during our inspection and were not assured that appropriate action was always taken to keep people safe.

As part of our inspection planning, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. Such information had not always been shared as required with the Commission by the provider. We are considering our regulatory response to the above concerns and will issue a supplementary report once this decision has been finalised.

This inspection took place on 01 and 02 November 2017 and was unannounced. The inspection was conducted by one inspector, a specialist advisor and an expert-by-experience whose area of expertise was dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a professional who assists us with current practice knowledge and expertise through our inspections.

We asked the provider to complete a Provider Information Return (PIR) to support the planning of our

inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not meet the minimum requirement of completing the Provider Information Return as requested. Some information was not readily available at the time of our inspection and we therefore requested this after our inspection visit, for example in relation to their investigation into complaints and incidents and audits relating to recruitment processes and quality assurance. The provider failed however to ensure all information was sent to us as requested and by the required deadlines. We took this into account when we made the judgements in this report.

As part of our inspection planning, we sought information from the local authority safeguarding team and commissioners of the service. We also checked whether any information was available from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four people living at the home, nine relatives, a nurse, two care staff and two senior staff members. We also spoke with the cook, an activity coordinator, the acting manager, operational and compliance manager and four professionals involved in people's care. We looked at records about six people's care, two staff recruitment files and records about the quality and safety of the service including quality assurance.

Is the service safe?

Our findings

At our last inspection in April 2016, we rated this key question as 'Requires improvement' because some people received unsafe medicines support. At this inspection, we found improvements were still required and were ongoing in this area. We also found further concerns which supported a rating of 'Inadequate' for this key question. This included two breaches of the regulations due to concerns around the provider's safeguarding processes and because some people's risks and safety incidents were poorly managed.

The provider's systems and processes failed to consistently protect people from risk of harm and abuse, although people and relatives told us they felt the home was safe. One person commented, "I feel safe and the staff are friendly." Systems to keep people safe had not ensured staff always understood how to identify and report abuse. One staff member was not aware of possible signs and types of abuse and did not recognise their responsibility to do so. Two other staff showed a basic understanding in this area and when they may have needed to make a safeguarding referral. Safety incidents and possible safeguarding matters were not always dealt with openly to learn lessons and promote people's safety when things had gone wrong. The acting manager told us they had needed to encourage staff to record safety incidents as staff had not always done so. This was to ensure incidents could be reviewed and learned from. We found however that incidents that had been recorded through the provider's processes were still not investigated effectively to identify learning and mitigate risks to people wherever possible. The provider had failed to inform the Commission and other partner agencies of incidents and safeguarding matters as required by law. For example, staff had intervened when a relative provided inappropriate support to one person in August 2017, however this concern had not been investigated to establish what happened and the information had not been shared as appropriate with relevant partner agencies. Some similar incidents such as falls and medicines errors had not been reviewed for example for any possible trends. These failures meant the safety and quality of people's care was not assessed in light of shortfalls in safety to prevent any further risk of harm to them. Prior to our inspection, the local authority safeguarding team informed us of a past allegation of sexual abuse which we instructed the provider to raise as a police matter. We ensured this incident was shared with third parties including the police for further consideration and we are considering our regulatory response to the concerns raised. We will issue a supplementary report once this decision has been finalised.

Failure to operate effective safeguarding systems and processes is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reasonable steps were not always taken to effectively manage all people's risks and learn from safety incidents. Two people requiring catheter care had been admitted to hospital in recent months. One person had been admitted to hospital twice within four months due to a catheter blockage. We prompted the provider to explore why this had happened because they had not identified this as a concern. The acting manager told us the person's continuity of catheter care may have suffered if agency staff were on duty as this care required particular skill. This was not an acceptable response to reflect learning and concern in light of this person's care. The other person had been admitted to hospital with uro-sepsis. Suitable risk assessments were not completed or up-to-date for this person's catheter care, either prior to, or following

their return from hospital. Shortfalls in the safety of this care had not been explored by the provider. In another example, one person became agitated and shouted during personal care. A staff member told us, "[Person is] like this every time, always like it and then afterwards says sorry." Staff confirmed the person had previously damaged a staff member's tooth during one altercation. The Commission had not been informed of this incident and the provider was not able to confirm when this had happened. This ongoing risk associated with the person's needs had not been referred to or monitored through their care planning. This did not help prevent similar reoccurrences or promote the safety and dignity of this person and others. Some routine health and safety checks helped keep people safe from risks posed by the environment and equipment use. The provider failed however to always ensure the safety and suitability of all people's equipment use. Although wooden bedrails were fitted for most people, including two people who we saw were cared for in bed, protective 'bumpers' were not in place to prevent people's discomfort and injury. There had been two incidents involving one person's use of bedrails in October 2017. This had included the person climbing over their bedrails which posed a risk of them falling and injuring themselves and reflected this equipment was not appropriate for their use. This had not however prompted a review of the risks and suitability of bedrails use for this person. Lessons were not always learned from incidents and risks to always ensure people's safe care and support.

Staff showed awareness of some people's risks and how to minimise these with advice sought as necessary from other healthcare professionals. For example, we saw and staff described appropriate measures and equipment they used to reduce some people's risk of developing sore skin. The acting manager told us one person had a pressure sore on their admission to the home which had since healed with input from tissue viability nurses. Records we sampled however showed the provider had not documented the wound care provided to this person and another service user, to demonstrate that appropriate and safe wound care was always provided.

Failure to provide care and treatment in a safe way and assess the risks to the health and safety of people using the service is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback as to whether there were always enough staff available to support people safely. One person told us, "There are enough carers, it's very busy. As soon as they can they help." A relative told us, "Staff know what they are doing but they are rushed and we don't see them often [near to the person's room]." One staff member told us, "There is enough time, it is busy and stressed at times but I do my best... There are enough staff as long as we're a strong team." Another staff member told us staffing numbers were increased as needed. Our observations found staff were not always visible to monitor people's safety or to engage people in activities or conversations outside of providing care. Some less independent people spent long periods of time doing little and without being approached. One person told us they were at risk of falls. A staff member told us this person had fallen in their bedroom and needed to be closely monitored to remain safe when walking. We saw however the person still walked around their room independently and this risk had not been mitigated to ensure the person's continued safety. The acting manager told us they routinely and informally monitored and amended staffing levels, however their assessment of staffing levels had not considered all people's social and safety needs.

One person told us, "[The home] is clean and well maintained." We saw people's rooms and communal areas were kept clean by domestic staff. Staff described appropriate measures they took to prevent another person's infection from spreading, although we saw some staff wore excess jewellery whilst on shift which is not in line with good practice guidelines for nursing care. Further improvements were required to ensure people were always protected through safe infection control measures. An infection control audit had been undertaken by the local authority after our inspection and had found good areas of practice although

improvements were required. We found that in October 2017, approximately ten people suffered symptoms and several staff were off work unwell due to a possible influenza outbreak. People were individually treated by the doctor and three people were admitted to hospital with pneumonia. The provider and management could not tell us any measures they had followed to prevent the spread of infection and confirmed they had not informed the Commission, local authority or sought the advice of the Public Health Agency on this occasion to ensure all safe possible measures were followed.

Previous areas of improvement identified at our last inspection had not been addressed effectively to ensure people always received their medicines safely. At our last inspection in April 2016, some people's tablets had been found discarded although staff assumed people had taken them. As during our last inspection, we observed that people were supervised when taking their medicines, for example, one person was kindly encouraged by a nurse until they took their medication. However, an incident record of October 2017 showed a person's antibiotic was found untaken in their drink by their relative. The incident record reflected this was a preventable error, however no further action had been taken to ensure learning from this error or notify relevant bodies of this incident. The findings of our last inspection and intelligence held on the provider showed such past errors had not been sufficiently learned from to prevent their reoccurrence. Recent developments at the time of our inspection had helped improve how people's medicines were managed. The provider had returned to using paper medicines records because staff were more familiar with this system. The acting manager had also sought the support of a pharmacist who conducted a medicines audit during our visit. One person told us, "They make sure I get my medication, and make sure I take it." Another person confirmed they were satisfied with this support and given pain relief as needed. We saw that people received appropriate support from the nurses with their medicines. The visiting pharmacist confirmed people's medicines were ordered on time and were stored appropriately. Their audit had identified some areas of safe practice, although further improvements were required that had not always been identified through the provider's processes. For example, relevant information was not in place for some people's medicines and prescribed creams. Discrepancies were found for two people's medicines stock. Improvements were still required and underway to promote and sustain the proper and safe use of people's medicines.

Our last inspection of April 2016 found that recruitment processes had been completed appropriately. At this inspection, two staff members told us they had completed checks through the Disclosure and Barring Service (DBS) and undergone reference checks to help assess their suitability for the role before they started work. We sampled their files and found that DBS checks had been completed before their start dates. Reference checks had been undertaken although they were not always clearly recorded to confirm who had provided these. The acting manager had recently reviewed the provider's recruitment processes and was addressing the concern that staff DBS checks had not always been renewed within three years as planned. Pin numbers to show that nurses were registered had been recorded and agency staff were used while recruitment processes were underway to fill nurse vacancies. Recruitment checks were carried out appropriately and improvements were underway to ensure this practice remained consistent.

Is the service effective?

Our findings

At our last inspection in April 2016, we rated this key question 'Requires improvement' due to poor support around keeping people well hydrated. At this inspection, we saw improvements had been made in this area. We have rated this key question 'Requires improvement' again however because all people were not always supported in line with the principles of the Mental Capacity Act (2005) and current good practice guidelines.

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. We saw some people's consent was sought and choices given for some basic decisions about their care. For example, a staff member told one person, "I'm going to wipe your face," and they did so with the person's consent. Another person was asked where they wanted to sit on entering the lounge. We asked a nurse how people were involved in their care planning and they told us, "Most [people] lack capacity. We do have a form which we can print off in that case and relatives can sign it." The records we sampled showed relatives were consulted on some changes to people's care and a senior staff member confirmed the doctor was also consulted to take decisions in people's best interests where necessary. We did not see however in those cases that assessments had always been completed to establish and confirm whether people lacked capacity to make their own decisions, or to consider what factors could possibly enable some people to make their own decisions. The provider's audits had identified that mental capacity assessments had not always been undertaken when identified as necessary, this was an ongoing area of improvement.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made DoLS applications for some people and their progress was tracked. Although staff had received some training in this area to help inform their practice, we found they had limited knowledge of the MCA. A senior staff member who was familiar with the MCA and DoLS did not know who had a DoLS authorisation in place. Our discussions with staff also found that some restrictions in place such as stair gates and a door code to prevent people leaving had been put into place due to historic risks. These restrictions had not been reviewed to assess whether they were still necessary to ensure people's safety and were in the best interests of people living at the home. Further reviews were required in this area and the provider told us this would be addressed.

People living with dementia were not always supported to have their needs met in line with current good practice guidelines. We saw that a staff member did not have the skills to adequately support one person when they repetitively called out for help and for a loved one who had passed away. The staff member moved away from the person to do other tasks and when they did initially respond to the person, they did so from a distance and without making eye contact which meant the person was not aware anyone was talking to them. On their return to the person, the staff member corrected the person by implying their loved one may no longer be alive given the person's own age. The staff member had not received training in dementia

care and did not adopt a suitable approach to help address and relieve the person's anxiety. People's needs associated with dementia were not always assessed and considered, for example through effective activity planning and the layout of the home. One person told us they saw it was hard for staff to include people living with dementia in activities. We found that activities were not always planned around or accessible to people living with dementia. The care records of one person living with dementia stated that noise levels caused them distress. We saw that an activity involved audios of animal noises being played repeatedly and very loudly in a communal area. Thought had not been given to the distress that the mixture and volume of noises could cause some people. Measures such as signage and pictorial information had also not always been considered in the design and decoration of the home to help navigate people. The provider told us they recognised the layout of the home had not always reviewed where some people had developed dementia and their needs had become more complex over time.

One person told us, "The doctor visits when needed and others like the dentist and optician come to visit." Some people's care had involved input from other healthcare professionals such as tissue viability nurses and palliative nurses where needed. A palliative nurse told us they had been involved in helping manage the needs and pain of one person and the person had received support as planned and to the satisfaction of their next of kin. Staff showed awareness of how to support people if they developed sore skin and told us they would contact tissue viability nurses if they were unsure of how to care for a wound. We found positive examples of how people were supported by some staff with input from healthcare professionals although further improvements were required to ensure this was consistent practice. Our sample of records and discussions with a doctor did not demonstrate that appropriate and planned action had always been taken to monitor and promote people's health. The doctor had formally complained to the provider because of delays in referrals to the doctor when some people were unwell or required end-of-life care. Staff told us they had experienced some frustrations and difficulties using an electronic system to access this support from the doctor. The acting manager had raised these matters and provided training to help staff become familiar with this and a staff member told us this had helped. The provider told us they intended to meet and develop closer partnerships with healthcare professionals involved in people's care.

Documentation was not always updated to ensure people's needs were always understood by all staff and monitored regularly as planned to ensure care always remained effective. Records showed some people's needs associated with healthcare conditions had been identified, but had not always been assessed and monitored as regularly as planned. For example, one person's identified risks associated with diabetes had not been evaluated and monitored for four months at the time of our inspection. Another person's risk assessments had not been updated following their return from hospital, to ensure this information reflected their changing needs. Prior to our inspection, the commissioning team had raised concerns to the provider as care staff did not always have ease of access to people's care plans. We found that this had not been addressed effectively at the time of our inspection. Furthermore, we found that information about people's individual preferences had not always been gathered to inform those care plans. Care records we sampled did not always reflect how dementia and mental health needs affected some people and the support they required accordingly. A nurse who had been assigned to review and improve the guidance in people's care plans told us, "We will know where to find what and what's missing." At the time of our inspection, people's needs were not always assessed in a timely way as planned, or their care plans completed to ensure staff had the guidance they needed about people's needs. Plans were underway to address this.

People, and relatives, we spoke with expressed satisfaction with the support provided. One person told us, "I feel that the staff have skills to look after me." A relative told us one person was, "Very well looked after." Staff showed they knew some people well through interactions and we saw some positive examples of how people were supported, for example, to move safely around the home. One person was encouraged to move carefully at their own pace which helped promote their safety and independence. Another person was

assured by staff as they were supported to move using a hoist which we saw helped the person relax. A hoist is a piece of equipment that staff use to safely move a person from one place to another when they are unable to move themselves. We also found some positive examples of the support provided to some people living with dementia. One person had an empathy doll which we saw they valued as they comforted the doll and folded their clothes onto a pram. A senior staff member described how they encouraged staff practice of telling, "Little love lies," to people living with dementia, as a kind way to reassure people if they became confused, for example about their whereabouts. This showed some recognition of current good practice guidelines in staff considering the person's perspective and identifying how to help them remain at ease.

Staff had received an induction and training in core areas of their role such as Moving and Handling and First Aid, however some training plans had not been kept up-to-date by the provider. A recently devised training matrix had helped identify and monitor where updates were required, particularly around end-of-life care, falls management and dementia care training. Staff told us they felt supported and described an improved experience since the acting manager had joined the team. One staff member told us, "I think care here is good. I would not be concerned if I had a relative living here. The staff are understanding of people's needs. I would never do anything here that I was unsure of and I have not been put in this position. Our [acting manager] is approachable." A relative told us, "In a lot of cases when we ask a question about [one person's] health if staff do not know they would ask the manager." We saw that nurses and senior care staff had daily updates about people's changing needs and risks to help inform how people were supported.

Since our last inspection, improvements had been made to ensure people had enough access to drinks and this support was monitored. A relative told us, "Mum has lots of drinks and is monitored, everything is written down." Our observations and sample of records confirmed this. People spoke positively about the food. One person told us, "The food is excellent, and we have a choice." A relative told us, "[My relative] is now eating well. The food is excellent, I have had meals here, and they do offer choices." Another relative told us, "There is enough to drink and the lunches are second to none." Food was freshly prepared and served promptly as displayed on menus in the dining area. We saw that two people enjoyed a roast chicken lunch at the table together and where one person did not like their lunch, they were offered an alternative. People's weights were monitored and staff described how one person had been referred to other healthcare professionals when they had lost weight and their dietary needs had changed. The chef confirmed they had details of people's preferred foods and how to prepare healthy meals in line with people's dietary requirements. People were supported to eat and drink enough to maintain a balanced diet of their choice.

Some care had been taken to ensure the design and decoration of the home was developed according to people's needs. One person told us they could see the outdoors and garden plants when they sat in the home's conservatory. They told us, "I find it more open here, that's why I like to sit here." A staff member told us there were private areas available for people to engage in prayer services as they wished. A relative told us their request for a room change had been met which meant the person was less disturbed by noise. Another relative told us, "If you want a picture hook, you just ask [the maintenance support]." We saw some people's rooms were adorned with photographs and personal items and relatives told us they had helped with this, although we saw some people's rooms remained bare, with little furnishing or decoration that was personal to them.

Is the service caring?

Our findings

At our last inspection in April 2016, we rated this key question as 'Requires improvement'. This was because staff were not consistently caring and people's dignity was not always promoted. We also found people were not always listened to or given information in a format they could always understand. We reported this under the key question Responsive in our last report. At this inspection, we assessed whether any improvements had been made and reported this under the Caring key question. At this inspection, we found that improvements were still required to achieve consistently caring practice and this key question rating remains at 'Requires improvement'.

We found inconsistencies around how some less independent people were supported to engage and feel part of the home. We found that staff were not always able to spend time with people outside of providing support and undertaking care tasks. One relative told us, "The staff are caring but you can see that they are overstretched." A staff member told us, "I do think that sometimes there are not enough staff when people are really ill or on end of life care. It would be nice just to be able to sit with people. It's sad." We observed some people were sat near to the nurses' station for long periods of time without being approached by staff or supported to engage in discussion. Our observations of one person found that they sat passively watching what was happening around the room. The person fidgeted with their mouth, rubbed their hands together and moved their hands on the chair on a number of occasions. The person had no conversation or activity to occupy them. Staff often walked by or sat near to the nurses' station but did not greet or engage this person or others whenever possible. Opportunities were not routinely taken for all people to be engaged with.

Although the interactions we saw between people and staff were often caring, we observed a task-based approach to some people's care which did not always promote their dignity and relationships with staff. For example, we saw that one staff member alternated between supporting two people to eat their meal at the same time. The staff member supported one person to have a mouthful of their meal, before alternating to offer the same support to the other person. This staff member looked around the room and engaged in some conversation with other staff outside of providing this support. This did not promote the dignity of those two people or enable them to engage with the staff member while they received support from them. We saw that people were supported in an order, one at a time by two staff members to use the bathroom. Most of those people were not asked by the two staff members beforehand, if they wanted to be supported with personal care at this time. This included two people who were interrupted from a group activity they were engaged in. We asked a staff member how they knew whether another person wanted personal care at this time. The staff member responded, "They will need it," yet failed again to check this with the person or tell the person what was happening.

A staff member told us they did not know anything about the preferences and identity of one person who had joined the home in October 2017. The staff member told us they had not been able to get to know this person as they were unable to express their needs verbally. We observed another staff member stood above this person's eye level and greeted the person from a distance. This approach had not enabled the person to acknowledge or identify they were being spoken to. We saw that the person continued to sit on this

occasion without experiencing engagement from staff or activity. Further improvement was required to ensure all people's communication needs were always understood and met as far as possible. This would help ensure people could always express their views and needs as far as possible and have these met.

We observed that more independent people were approached and enjoyed laughing and chatting with staff. As music played in the lounge area, a staff member said to one person, "I bet you've danced to this a few times." The person laughed and joked with the staff member about this. A relative told us about another person who spent time in their room: "They like music and staff make sure their radio is on. They also celebrate birthdays and make a fuss of residents. [Person] socialises so much more than they have done for years." We saw people were well kempt and dressed to reflect their identities and preferences.

Since our last inspection, some pictorial menus had been developed and displayed to ensure this information was more accessible to people. People told us they felt able to express their views about their care and support. One person commented, "I'm asked every day if everything is alright... When I first came, I was asked about my choices and preferences. There are people who care about what you need." Another person told us, "I have been involved in residents' meetings, I feel listened to, we just recently had a meeting." Residents' meetings were held for people to talk about their support, for example what activities they wanted to do. We saw other efforts had been taken to meet some people's communication needs. For example, one person's bedroom door displayed a reminder to enter the room to address the person so they had time to understand what was being said to them. We saw that some people were able to call out for and request the support they needed and we saw this was often responded to.

We observed some positive examples of caring practice and people and relatives told us that staff were caring. One person told us, "The staff are approachable, I can speak to them about [my health needs]." Another person told us, "The staff are very friendly." A relative told us, "The staff are caring and very patient." We saw that one person was welcomed when entering the lounge. They were supported to their chair by staff and offered a blanket to help them feel comfortable. We saw that staff responded in a caring matter when another person became upset. One staff member wiped the person's tears away and listened when the person explained what was wrong. The person settled after talking to the staff member and a nurse, and after encouragement of what they could do to help take their mind off this. Feedback also reflected that people felt that their dignity was promoted. One person told us, "Staff respect my dignity and respect me. When they come to wake me in the morning they knock, and they make sure the curtain and door is closed whilst giving me personal care." A relative told us, "Staff are very caring and speak to [person] when providing personal care."

Is the service responsive?

Our findings

At our last inspection in April 2016, we rated this key question as 'Good.' At this inspection, we found that good practice had not been sustained. We have rated this key question, 'Requires improvement' and identified a breach of the regulations due to some concerns around care planning and delivery, including for some people's end-of-life care. Improvements were also required around how complaints were learned from.

Care planning processes had failed to consistently gather sufficient detail about people's needs and preferences to promote person-centred care. We found that staff were often aware of people's personal care and nursing needs, however, the provider had not ensured information about some people's identities, life histories and interests were always gathered and known to all staff. One person's care plan provided specific and personal detail including their life history and staff could tell us such information for another person. Another person's care records lacked this information. We asked the acting manager and a staff member to tell us about the life history and identity of a person who had joined the home in October 2017. The acting manager told us, "We don't know much about [person]." The staff member told us, "I can't tell you anything, I'm not very informed." The acting manager told us basic information had been gathered about this person during their initial assessment and staff still needed to speak to the person's relatives to learn more about the person. Our discussion with a staff member showed this had not been done.

At the time of the inspection, system issues prevented some staff ease of access to people's care plans. We saw a staff member knew how to update daily care records onto an electronic system but they could not locate information on the system about people's care needs and preferences. This had been raised as a concern by commissioners since our last inspection and was being addressed by the provider. We saw that a nurse was in the process of developing people's care plans. Although the nurse told us they were due to gather details of one person's social history and communication needs from their family, earlier opportunities to do so had been missed however as this person had moved onto end-of-life care at the time of our inspection. People who were able to independently express their needs and choices told us they were involved in their care planning. One person told us, "I was involved in my care plan, in fact I had an assessment the other day." A relative told us they had been involved in reviewing another person's care plan and commented, "We are happy with [person] being here, they are happy and contented which tells me that [person] is well looked after." At the time of our inspection, processes did not ensure staff always had key information about all people's needs and preferences to promote person-centred care.

At the time of our inspection, end-of-life care was provided to three people with the involvement of palliative care professionals and steps taken to manage people's pain. One person's expressed final wishes had recently been recorded before they had approached their end-of-life. The requested funeral arrangements for another person who was not at end-of-life, had been proactively gathered through care planning. Improvements were required to ensure people could be confident they would always receive end-of-life care in line with their wishes and needs. Reasonable steps had not always been taken however to gather and keep under review people's end-of-life wishes. One person was at end-of-life care at the time of our inspection and staff told us they were trying to ensure the person's wishes would be met following a discussion with their relatives. Earlier opportunities had not been taken to document the person's end-of-

life wishes and their care records stated this still needed to be discussed. A doctor told us they had formally complained to the provider in October 2017 partly due to recent delays from the provider in referring people to the doctor when they joined the service requiring end-of-life care. This had prevented the doctor's timely reviews of people's care needs around pain relief and advance decisions. The doctor told us they had needed to repeat discussions with one person about their advance decision because the relevant completed documentation had been lost on the person's arrival to the home. Staff had later found this documentation which had not been logged and filed appropriately for safe keeping. Systems were not effective to ensure people's end-of-life wishes were gathered and kept under review. The acting manager told us they were reviewing all people's care plans to rectify this. The acting manager was arranging end-of-life training to ensure all staff would be equipped to provide this support, as only a small number of staff had received training in this area.

Failure to ensure people receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be, is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems did not always demonstrate how complaints had been addressed and used to improve the service, although people and relatives expressed satisfaction with this aspect of the service. One person told us, "I have no complaints or concerns." Another person told us, "If I wasn't happy, I feel I could say. The [acting] manager comes around and speaks to me so this is the perfect opportunity to say. They would act and try to address it." A relative told us, "I have complained and it was dealt with so no need to mention it." People and relatives we spoke with felt able to raise concerns and we saw that they had accessed the provider's complaints process. Our discussions with a healthcare professional and our sample of records did not demonstrate this was a consistent finding. A healthcare professional told us however that they had raised several concerns with the provider before receiving a response. Records we sampled showed the provider issued a response around the time of our inspection, although this response was delayed. Complaints records we sampled did not always demonstrate how complaints had been responded to and used to drive improvements. For example, a complaint logged in May 2017 detailed a relative's concerns that their requests about one person's care had not been listened to. We saw no explanation had been given in response to the relative's initial request or to the complaint.

We looked at people's access to activities. One person told us, "There are always lots of activities going on." Another person told us, "My hobbies are jigsaws and playing games on the computer. I have started a trend here now, others are now doing jigsaws." Some independent people spent time engaging in tasks of interest to them as they pleased, this included reading and playing cards. Where one person had been bought flowers, we saw the activity coordinator made a fuss of these with the person and helped the person to arrange the flowers. The activity coordinator was often visible in the lounge and encouraged some group and individual activities. They knew some people's individual interests and gave examples of how they tried to incorporate those interests activity planning. Improvements were required however to ensure activities were always accessible to less independent people and people living with dementia. We observed some less dependent people often sat without being approached by staff or engaging in an activity or conversation. Some care was taken to meet people's cultural and religious needs. Staff told us one person's first language was not English so they were learning phrases to try to communicate with the person. Although we saw examples of this to which the person responded positively, there were occasions where the person spent long periods of time without being spoken to by staff or others. The person was given alternative meals of their preference and was supported to access television channels and music of their preference and first language. A staff member told us they joined another person in night prayer and commented, "For me it's really important, I share [person's] beliefs and it's helping them." People were given privacy to participate in religious services as they wished. The acting manager also gave examples of how the diverse needs of the

staff group were recognised and met, for example to support staff during religious fasting periods.

Is the service well-led?

Our findings

At our last inspection in April 2016, we rated this key question as 'Requires improvement' as systems were not effective to ensure the quality and safety of the service. We had found improvements required around people's support with medicines and hydration, in addition to concerns around the provider's record keeping and responses to concerns and feedback. We found sufficient improvements had not been made to the governance of the service since our last inspection. Our findings that systems and processes still failed to always ensure the quality and safety of the service supported a continued rating of 'Requires improvement' for this key question and a breach of the regulations. We identified a second breach of the regulations because the provider failed to notify the Commission of events and changes at the service as required by law.

The provider had failed to uphold all of their responsibilities to the Commission. The provider did not meet a minimum requirement of submitting a PIR before our inspection. A PIR is key information about the service that we require providers to send to us, including what the service does well and improvements they plan to make. During our inspection we found the provider had failed to meet the legal requirement to the Commission of safeguarding matters, incidents and changes at the home. The provider had not identified that a previous manager of the home had not de-registered after leaving in 2014. The provider had also failed to inform the Commission and other relevant partner agencies of incidents and complaints alleging the possible neglect of some people. Despite our request for the provider to take action to rectify this, they failed to assure the Commission they had done so in a timely way and that their processes would be reviewed to prevent future failures in this area.

Failure to notify the Commission of specific events as required is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009.

The provider did not have effective systems to oversee the quality and safety of the service and ensure good quality care was maintained despite managerial changes. Our inspection findings of April 2016 found the provider's oversight had failed to identify a number of issues that required improvement. The acting manager at this time told us quality assurance was a key aspect of their plan for running the home. There had been further managerial changes since this time and we found that the acting manager at the time of this inspection had similarly found areas of improvement that had not been picked up by the provider. A relative told us, "There has been a constant change in management which is unfair to staff, managers change things and then leave." Some audits conducted by the provider and a Quality and Compliance Manager over recent months had identified some necessary improvements, however those audits did not encompass all aspects of the service or identify shortfalls in practice that we found, for example, in relation to equipment use and monitoring of people's risks.

The provider's systems for responding to information held within the service such as safety incidents and changes to people's needs were not effective. This had failed to drive improvements to the safety and quality of the service. Records we sampled showed the provider's process had not always been followed to investigate and learn from incidents and complaints in order to prevent their future reoccurrence and

mitigate risks. For example, one person's risk had not been reviewed to explore the suitability of bedrails, although they had climbed over this equipment and could have suffered harm and injury as a result. Hospital admissions relating to an outbreak of influenza and following issues with catheter care had not prompted a review of this support at a service level to learn from safety incidents and ensure people always received safe and appropriate care. We found the care provided and the layout of the home did not always meet people's needs associated with dementia. Current good practice guidelines had not been referred to, to help inform good dementia care planning. We saw improvements were also required with how some staff communicated with and involved people living with dementia in activities. The provider later told us they intended to ensure improvements in those areas through dementia care training for staff and their ongoing plans for person-centred care planning.

The provider's systems had failed to ensure all staff always had access to current information about people's needs and preferences. This information was stored electronically yet staff had not always been given full access to this system. A senior staff member told us, "I can access care records, carers can't. Some are printed. Systems give people the information needed and we show new carers what [information] we've got, we encourage reading. When I forget [information], I check." Another staff member did not know where to find some people's care plan documentation. Staff could add daily care information to the system but could not always access information about people's needs and preferences. One person was prescribed medicines for depression yet there was no guidance for staff about how to meet their needs associated with depression otherwise. Other risks identified for this person were not reviewed monthly as planned and the provider's oversight had failed to address this. The provider was taking remedial action to address this at the time of our inspection. An additional nurse had been assigned to print and develop people's care plans so staff would have improved access to information about the people they supported.

Records to monitor people's daily needs and changes were not always completed consistently. We found for example people's hydration and fluid charts were often completed correctly, yet although one person's care plan had been signed as evaluated on the day of our inspection, the care plan had not been updated to reflect changes to this person's needs and their overall health deterioration. We found that people's care plans were not routinely evaluated as required to ensure their needs were always safely met. In another example, we saw one person was supported with a smaller sling than the size specified in their care plan. This person did not show signs of discomfort when using this smaller sling. However, when we raised this with the nurse and acting manager, they changed the person's risk assessment to instruct staff to always use this smaller sling size, without conducting an assessment and measurements to ensure this smaller size was suitable for the person. They told us they relied on the feedback from staff and that records should contain the correct information for staff. Upon further investigation, we found the provider was not able to provide any evidence to show how and when sling size measurements had been carried out for people who required hoist support, in order to demonstrate people were suitably supported to use appropriately sized slings.

Failure to effectively establish and operate systems and processes to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider gathered people's views and experiences and acted on their feedback to shape and improve the service and culture. This topic area was reported under the key question of Responsive following our previous inspection. This topic area has moved to this key question when the inspection framework was reviewed and refined. At our last inspection, the provider told us improvements were planned to ensure people's views and feedback were gathered, to help monitor and drive the quality of the service. At this inspection, we saw that people and relatives had some involvement with care planning where possible and could share feedback at residents' meetings and through the provider's complaints and

compliments processes. People and relatives often reported a positive experience of the home although we found that complaints and compliments had not always been reviewed to help assess and drive the quality of care provided. The provider told us they had plans to further develop relationships with healthcare providers involved in people's care. This would help support work undertaken by the acting manager. The acting manager had responded to feedback and guidance sought from a pharmacist and we saw this had led to ongoing improvements in medicines management. The acting manager had provided additional guidance to staff to try to alleviate concerns experienced when using a new system to refer people for further healthcare support. The commissioning team of the service told us that since our last inspection, they had raised and monitored issues at the home around systems and processes and we found that improvements were still required at the time of our inspection.

Staff received some support from consistent leadership and told us they felt supported. A manager who was registered to the service was on planned leave at the time of our inspection. The provider had notified us of this change and recruited an acting manager in the interim who had joined the home in August 2017. A senior staff member told us, "[The acting manager] has done a fantastic job, [they have] turned the place around really quickly, putting the hours in. They talk and guide you through things you're not sure of." A relative told us, "The manager is approachable." The acting manager had supported ongoing improvements in medicines management and ensured policies such as infection prevention and control processes, and recruitment practices were updated. Following their previous care roles at the service, a senior staff member had been promoted in recent months to provide support and oversight to care staff. The staff member showed they knew people's care needs well and commented, "I've got very high standards expected by carers on my shift," and described how they effectively communicated people's changing needs with nurses and the chef.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to ensure people receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

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 provider failed to provide care and treatment in a safe way and assess the risks to the health and safety of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider failed to operate effective safeguarding systems and processes.