Mrs G H Copley

Lands House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 20 and 25 January 2016 and was an unannounced inspection. On the date of the inspection there were 16 people living in the home. Lands House Nursing Home provides accommodation and nursing care for up to 30 people at any one time. The home is located in Rastrick, Brighouse with accommodation spread over two floors. The client group was mainly older people, some of whom were living with dementia.

A registered manager was not required as the provider was a single individual who also undertook management duties within the home. Following the previous inspection, the home had appointed a nursing manager in November 2015 to provide nursing oversight of the service. Sadly they had died unexpectedly in early January 2016. At the time of the inspection, there was no nursing oversight of the home, with only two registered nurses available to work days. Due to shortages of nursing staff the clinical lead was unable to work any supernumerary time allocated to nursing management duties.

People and their relatives told us that the service was safe and it provided good, effective care. They said staff were kind and caring and treated people well. They said that they felt safe from abuse in the company of staff.

At the last inspection in July 2015 we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, for example to care planning documentation and the management of nutrition. We found interactions between staff and people who used the service were improved.

However there was insufficient improvement made in a number of other areas, including the management of risk and the evaluation and improvement of nursing care. Concerns remained about the management teams understanding of a number of key topics including the Mental Capacity Act and safeguarding.

We found some aspects of the medicine management system had been improved. For example the administration of Warfarin was better managed and for boxed medication, there were no gaps on Medication Administration Records (MAR) demonstrating people were regularly receiving their medicines. However there was a lack of appropriate procedures and care planning to support the safe and consistent administration of medicines. We found two people did not receive the medicines at the times they needed them.

Staffing levels were sufficient to ensure safe care. Requests for care and support were responded to promptly by staff.

At this inspection we found there was better recording of incidents which had occurred within the service. However we were concerned that the management team were not correctly identifying incidents as

safeguarding and referring onto the local authority. We found risks to one person were not appropriately managed and risks assessments put in place were not robust enough to provide us with assurance that further incidents would not occur.

The home was not complying with the legal requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where DoLS were in place the conditions were not being complied with and the management team had a lack of understanding of the correct processes to follow.

Improvements had been made to the way the service managed risks associated with poor nutrition.

There was a lack of systems in place to provide nursing staff with proper and worthwhile clinical supervision. There were some gaps in the training records which showed some nurses had not received their mandatory training.

We observed staff were kind and caring and treated people well. People were listened to and their choices respected with regards to daily life within the home.

Since the previous inspection care records had been improved. In most cases, they demonstrated a better assessment of people's individual needs. However further improvements were needed to some records to ensure they accurately reflected people's care and support needs. The provider acknowledged this process was not yet fully complete.

Records showed that people were involved in a number of activities to help keep them occupied.
A range of audits were undertaken by the service and we saw evidence these were used to improve a number of aspects of service delivery. Regular meetings with staff groups had also been used as a mechanism to improve the service. However the provider acknowledged that further improvements were required, however these were not formalised into a structured action or improvement plan.

There was a lack of systems in place to assess, monitor and improve the quality of nursing care within the home. We were concerned that audits of nursing care plans and investigation into nursing incidents were being completed by the provider who was not a registered nurse.

We were concerned that some issues we found at the previous inspection such as not working within the legal framework of the Mental Capacity Act (MCA) and a failure to manage risks appropriately were still present. This showed a lack of action taken to fully address these areas based on our feedback.

Overall, we found significant shortfalls still remained in the care and service provided to people. We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

Although some improvements had been made to the medicine management system, people did not always receive their medicines at the times they needed them. Effective policies, procedures and care planning were not in place to support the safe and consistent management of medicines.

People and staff we spoke with told us they felt safe in the home and comfortable in the company of staff. Risks to people's health and safety were not always appropriately managed. We remained concerned about the service's ability to identify risks, alert the relevant external bodies and put robust plans in place to protect people from harm.

Staffing levels were sufficient to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

We found the service was not acting within the legal framework of the Mental Capacity Act and Deprivation of Liberty Safeguards and the management team had a poor understanding of their responsibilities in these areas.

We found gaps in the provider's training provision with some nursing staff not receiving their mandatory training. There was a lack of robust clinical supervision and oversight of nursing skill and competency.

Improvements had been made to the way nutritional risks were managed. People's weight was appropriately monitored and referrals to external health professionals took place.

Is the service caring?

Good

The service was caring.

People and their relatives all told us they thought staff were kind and friendly and treated them well. They said that staff provided

a good level of care.

We observed care and support. We saw people were treated with dignity and respect. Staff listened to people and asked their consent before helping with care and support tasks.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Following the previous inspection, we found a general improvement in the quality of care records which demonstrated a better assessment of people's individual needs. However these improvements were not complete and we found some inconsistencies in the information recorded within care plans.

The provision and evidencing of activities for people who used the service was improved.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not submitted all required notifications to the Commission, for example it had failed to notify us of the 10 DoLS authorisations in place.

Although improvements had been made in areas such as care planning, nutrition and dignity and respect, there were still significant concerns that remained. These should have been addressed through a robust system to improve the quality of care within the home.

There was a lack of nursing oversight within the home and a lack of systems to monitor and improve the quality of nursing care.

Lands House

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 required improvements had been made to the service following our inspection in July 2015. As the inspection was a comprehensive inspection we also looked at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 20 and 25 January 2016 and was unannounced. The inspection team consisted of three inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support within the home. We spoke with five people who used the service, three relatives, two registered nurses, four members of care staff, the cook and the administrator. We also spoke with the provider and deputy manager. We spent time observing care and support being delivered. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspections we normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion. We reviewed all information we held about the provider. We contacted the local authority safeguarding and commissioning teams and the clinical commissioning group to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in July 2015 we identified a number of concerns with regards to the management of medicines. This included people not receiving their medicines as prescribed and unsafe practices in the administration of warfarin. We also found the home was not following recognised safe guidance for example in administering covert medicines in line with current guidance.

At this inspection we found improvements had been made to some aspects of the medicine management system, we found people were consistently receiving their boxed medicines and there were no gaps in Medication Administration Records (MAR).

We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. Medicine fridge temperatures were taken daily and recorded.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We saw all prescribed food supplements were administered correctly, with the nurse taking care to ensure they were consumed. We saw evidence people were referred to their doctor when issues in relation to their medication arose and the home was responsive to advice from the doctor with regards to changes to medication.

However we found the medicines management policy did not provide a framework for the safe management of medicines. The copy of the policy we were given by the clinical lead was not fit for purpose. The policy did not make reference to current accepted guidance, (Managing medicines in care homes - National Institute for Health and Care Excellence (NICE) guidelines March 2014). Furthermore, we could find no written policy with regard to the administration of medicines via a percutaneous endoscopic gastrostomy (PEG) despite two people receiving their medicines via this route.

We witnessed the administration of medicines to one person via a PEG. On the day of the inspection, our observation of the technique to administer medicines via a PEG showed the medicines were given safely. However whilst the medicine was administered safely there was total reliance on the nurse's own professional judgement which may not comply with another body of nursing opinion. At the very least there was no consistency in the amount of water being used to flush between each medicine. This in itself was not an indication of unsafe practice but did indicate uncontrolled practice which may vary across the nursing workforce at Lands House. This was of particular significance because a safeguarding alert was raised on 15 January 2016 by an external health professional concerning poor practice in the administration of medicines via PEG by a member of the nursing team. In the absence of clear care planning and direction to nursing staff there was the risk of inconsistencies in practice.

'As necessary' (PRN) medicines were not supported by written instructions which described situations and presentations where PRN medicines could be given. The absence of a protocol falls short of the guidance given by the National Institute for Health and Care Excellence (NICE) and increases the risk of inconsistencies in administration.

We asked the nurse about the safe handling of medicines to ensure people received the correct medication at the correct time. Answers given and our observations through the morning demonstrated medicines were given by trained staff yet their knowledge was not consistently being translated into good clinical practice. On two occasions we found medicines were being administered contrary to the prescribers' wishes. One medicine stated it should be given with food or afterwards, yet it was given before. Another person was prescribed an antibiotic to be given four times a day in equal spaced doses before food. We observed the medicine being administered at 10:40 which was after breakfast had been taken. Furthermore an administration at 10:40 also compromised the ability to give the midday dose before lunch and ensure the doses were equally spaced. Whilst our observations showed sub-optimal practices we did see some evidence of good practice to ensure other medicines were administered at the correct time.

We found one person's records showed they frequently declined support with aspects of their care such as personal hygiene and the application of topical creams. The records showed the person had a red area and was prescribed a topical cream to be applied three times a day. The record did not state where the cream was to be applied and this was not identified on the body map. The record showed the cream had not been applied at all in the nine days leading up to our inspection and had been declined over 13 days in the period between 14 December 2015 and 9 January 2016. There were no records to show the person's GP had been notified about this and the wound care plan had not been updated since 16 November 2015.

This was a breach of regulation 12 (1) 2 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People who were able to talk to us told us that they felt safe in the home. One person said, "I like it here. I've been here a long time and I feel safe." Other people looked relaxed in the company of staff. People's relatives we spoke with did not raise any concerns about people's safety. One relative told us, "It was a big decision to move our [relative] here or to any care home. I had provided care at home for two years but I became unable to meet their increasing needs. I have no regrets about our [relative] being here."

Care staff demonstrated they were aware of the signs of possible abuse of people and they knew what action to take, should they suspect someone was being abused. Staff told us they were confident to report any suspicions they might have about possible abuse of people. However, we found the provider and deputy manager did not have a thorough understanding of local safeguarding procedures. They had not appropriately recognised incidents as safeguarding and made appropriate referrals to the Local Authority and Commission. Without raising incidents as safeguarding alerts, risks may not be managed safely with the appropriate professional input.

This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we found risks associated with bed rails were not safely managed. At this inspection, we found improvements had been made. Bed rails were safely utilised and were fitted as specified in The British Standard BS EN 60601-2-52:2010 thus posing no risk of entrapment.

Risk assessment documentation concerning areas such as nutrition and behaviour was much improved. We

saw it had been used appropriately to identify and manage risks to people.

At the previous inspection in July 2015 we raised concerns about how risks to people's health and safety were identified and managed. At this inspection we found the provider had made improvements to the way it documented incidents. Following most incidents there was evidence of preventative measures put in place to prevent a re-occurrence evidenced through new risk assessment and incident documentation. However this was not universally so. We remained concerned that the risks to one individual were not appropriately managed. At the previous inspection, the deputy manager told us about a safety related incident that had occurred where a person had managed to exit the home due to the front door being open. At the time we had concerns that the service had a poor grasp of how to sufficiently control the risks and keep this person safe. At this inspection, we found a near miss had occurred in September 2015 and another incident had occurred in December 2015 where the person had absconded and had to be brought back to the home by a member of the public. Although the details of this had been documented on an incident form, the explanation from the manager and preventative measures put in place were still not satisfactory to keep this person safe and did not provide us with any assurance that a re-occurrence would be prevented. Due to this risk, following the inspection, we made a safeguarding referral to the local authority.

At the last inspection in July 2015 we had concerns that personal evacuation plans were not sufficiently robust. At this inspection we found this still to be the case. For example one person's personal evacuation plan stated 'would panic in an emergency' but there was no further information recorded. In addition the evacuation plan folder also contained some people who were not longer residents in the home. The deputy manager told us they were in the processing of updating the file but it was not yet complete. This meant that accurate and complete information was not available in the emergency folder relating to people's evacuation should it be needed during an emergency.

This was a breach of Regulation 12 (1) (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider had a robust recruitment policy with staff records generally evidencing its appropriate application. The procedure included obtaining two character/professional references, confirming identification and checking people with the Disclosure and Barring Service (DBS). Evidence was available to show staff working in the home had a DBS check completed. We saw registered nurses provided evidence of current registration with the Nursing and Midwifery Council (NMC). These showed checks had been completed to protect vulnerable people from staff unsuitable to care for their needs. However, we identified one nurse had been recruited with a poor reference but there was nothing documented as to whether this had been considered during the recruitment process.

At the last inspection we found there were insufficient care staff deployed to meet people's needs. At this inspection the number of people living in the home had reduced from 25 to 16. We found overall there were sufficient numbers of staff deployed to ensure people's needs were met. We saw staff were present in communal areas and responded promptly to people's requests for assistance. We found there were sufficient staff to meet people's needs and noted ancillary staff assisted the care staff during mealtimes We examined rota's which showed a general consistency in the number of staff working each day in line with planned levels. The deputy manager, laundry and cleaning staff also helped out with care duties at busy times such as mealtimes. People and their relatives did not raise any concerns with us about staffing levels. One relative told us, "Of late there always seems to be enough staff about."

The home had only two full time nurses available to cover day shifts. Whilst rotas showed us that shifts were

covered, we were concerned that this would not be sustainable in the long term. It also meant that the clinical lead did not have any supernumerary time allocated and therefore there was a lack of nursing management oversight.

We found the home to be clean and fresh with no offensive odours. Cleaning checks were undertaken. The home had recently achieved a five star food hygiene rating from the local authority.

We completed a tour of the premises as part of our inspection. This included bedrooms, bathrooms and shower rooms. We found the premises to be safely managed and some improvements had been made since the previous inspection. For example, the 'barn' communal lounge which we previously noted to be in poor condition had been closed, one of the downstairs lounges re-arranged and a new dining room provided upstairs, which was an improvement on previous arrangements. However, there was still work to be done to bring the premises up to a high standard such as addressing tired décor and fixtures. The provider told us they had plans to improve the environment further in the future.

We inspected records of lift and hoist maintenance and found all to be correctly inspected by a competent person. We saw certificates confirming safety checks had been completed for gas installation, electrical installation, fire appliances and alarms and boiler maintenance.

Inadequate

Is the service effective?

Our findings

Relatives we spoke with generally said the care provided was effective. They said they thought the home provided appropriate care and support. For example one relative praised how their relative's weight and general condition had increased since admission stating, "Can't fault them."

At the last inspection we had concerns that some staff and management did not have the skills and competence to undertake their role safely and effectively. At this inspection, concerns still remained. We were concerned about the provider and deputy manager's lack of understanding of safeguarding and Mental Capacity Act (MCA). The local authority told us they were concerned that the provider, manager or any staff had not attended detailed managers training on MCA/DoLS to increase their understanding in this area.

We were concerned staff were assigned to assist people with their meals when they were not competent or confident in this role. For example, we observed one of the ancillary staff assisted a person with their meal. The person was pouching food in their mouth and the staff member was unsure what to do and asked the care staff who were assisting other people what they should do. One of the care staff advised them to give the person a drink but we heard the staff member say, "I can't get (the person) to get it out. I can't do this." At this point one of the care staff took over and calmly dealt with the situation appropriately. When we looked at this person's care records there were instructions from the speech and language therapy (SALT) team which stated, 'not to clear the throat by drinking as this may cause to inhale and post intake cough, try not to overfill the mouth." This demonstrated staff assisting this person did not have the knowledge to support the person correctly in line with their agreed plan of care.

We also found there was a lack of a robust system of clinical supervision in place to support nursing staff to ensure the development and maintenance of professional skills and enhance the quality of care. This was particularly significant given we identified concerns with nursing practice at previous inspections and in January 2016 two external health professionals told us and documentation in the home showed they had concerns over nursing practice within the home. Nurses had received some supervision but many of these were very brief and the same format as the care worker supervision form. They did not reflect on incidents and their nursing practice. The provider told us they were currently looking at providing better clinical supervision but it had proved difficult to source. In addition, nurses had not received any appraisals during 2015.

On induction we saw staff completed a local induction which oriented them to the providers' ways of working. However we found gaps in the training for some staff. For example records showed one nurse had not been provided with mandatory training since joining the service in August 2015. In addition, they had not received any checks on their competency to ensure they were working safely. Another two nurses had not completed the majority of their mandatory training including safeguarding, health and safety and food hygiene. The deputy manager agreed that some staff were out of date with training and required updates.

At the last inspection in July 2015 we raised concerns about staff competency in completing the MUST

(Malnutrition Universal Screening Tool). However training records showed no staff had received any refresher training in MUST following our findings in July 2015.

This was a breach of Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw 11 standard authorisations had been sought for people currently living at the home from the supervisory body. Of those applications 10 had been authorised. We saw evidence relatives had been consulted as part of the application process. We looked at the authorisation which had conditions attached. Our overall conclusion was that conditions attached to people's DoLS were not being complied with in sufficient detail or with sufficient speed. We found the management team's collective knowledge of the Mental Capacity Act 2005 and DoLS legislation was inadequate.

We looked at four people's DoLS with conditions attached. In one case, we saw the managing authority had made some attempt to meet a condition through the development of a care plan around behaviour. We saw staff following this care plan during the inspection. However following scrutiny of care plans it was clear conditions were not being addressed with sufficient speed or diligence as the supervisory body required. For example, one person had a condition referring to the need to ensure adequate nutrition. The apparent lack of capacity required the managing authority to carry out mental capacity assessments to ensure the person was adequately nourished in as least restrictive way as possible and that their nutritional health status was monitored. We found no evidence this condition was being complied with. In addition when we spoke with the manager and the assistant manager we gained no assurance they had a full grasp of what was required to comply with the condition. They were unable to quantify the scope of mental capacity assessments that were required and how the outcome of these assessments may be translated into a constructive care plan as required by the supervisory body.

We looked at another condition in another person's DoLS authorisation. The authorisation had been in place for five months. One of the conditions required the managing authority to ensure care planning was reviewed regularly to ensure least restrictive options for care were reflected in the care plan. We found no evidence of regular reviews in the care plan other than a review four months before. We spoke with the relevant persons representative (RPR) to ask whether they had been involved in any care planning reviews or been invited to a best interest meeting. We were told no approaches had been made by the managing authority to the RPR.

During our discussions with the manager and the assistant manager regarding the conditions attached to people's DoLS we were told some people's circumstances had changed or they as the managing authority believed people's mental capacity had changed or was fluctuating. The DoLS code of practice states, "When a person is deprived of their liberty, the managing authority has a duty to monitor the case on an ongoing

basis to see if the person's circumstances change – which may mean they no longer need to be deprived of their liberty". We asked why in such circumstances they had not triggered a Part 8 Review with the supervisory body. Their response indicated they had no understanding of the term or the process. A Part 8 Review under the DoLS can be triggered by either a managing authority, the relevant person (i.e. the detainee) or their representative requesting the supervisory body (who authorised the detention in the first place) review the authorisation. The managing authority must request such a review if they feel that a person's circumstances have changed, and so they may not meet the qualifying requirements for detention under the DoLS or the attached conditions.

This was a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Care and treatment was not planned within the legal framework of the Mental Capacity Act (MCA). We found where people lacked capacity to make decisions for themselves, and professional opinion over their care and treatment option differed, there had been no best interest meeting set up to discuss the person's plan of care and treatment to find a solution that would be in their best interests. In another case we saw someone who had been under the care of the dietician had regularly been refusing food. No mental capacity assessments had been completed to determine if this person had capacity to understand the decisions they were making and the consequences for their health.

We looked at the care records for one person who had a DoLS authorisation in place. This person had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form dated 17 March 2015 which stated the person had capacity and did not agree with the decision. This had not been reviewed since the DoLS authorisation had been issued.

This was a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we had concerns about the management of people's nutrition by the service. At this inspection, we found overall improvements had been made. We spoke with the cook who had a good understanding of people's needs. Information was displayed in the kitchen which showed people's dietary requirements. The cook described how they fortified meals adding extra butter and cream to food where people needed additional calories and provided milky drinks, cakes and high calorie smoothies between meals. We saw these being offered during our visit. The menu was displayed in the lounge and the cook told us an 'alternative options' menu had been introduced since the last inspection. This included a range of different meals people could have and we saw the cook went round asking people what they would like for lunch.

People told us they enjoyed the food. We saw people were offered breakfast as they got up throughout the morning and two people said they enjoyed the bacon sandwiches they had. We observed lunch in one of the lounges. We saw there was quite a long wait for the meal as people were sat at the table for over 30 minutes before the food arrived. However, there was a pleasant relaxed atmosphere and staff chatted to people as they waited and offered them drinks. When the food arrived staff helped people with their meals.

Nutritional risk assessments and the MUST (Malnutrition Universal Screening Tool) were better completed although we found one instance where the MUST score was incorrectly calculated. We saw evidence staff had been encouraged to help maintain good nutrition through the provision of high calorie snacks and drinks between meals. Food and fluid records we saw were better maintained and confirmed people were offered a range of snacks between meals.

People had access to a range of health professionals. The home was receiving significant support from local health agencies and as such people had regular contact with health and social care support workers this included QUEST matrons, district nurses and doctors. We saw their advice was recorded in the people's files to assist staff. During the inspection we examined a memo sent to nursing staff in January 2016. It stated that one group of external health professionals had concerns that the home was not referring appropriately to them and not using their nursing skills to diagnose and manage people's conditions. Another healthcare professional also told us they were concerned about the nursing skills of some staff within the home. A third health professional told us they found the deputy manager was very helpful and 'knew what was going on' in the home.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and treated them well. One person told us staff cared for them and protected them from harm. They said, "I am very happy here and I have everything I need." Another person said, "Staff are okay here, we get on well. I'm all right, love."
People looked comfortable in the company of staff for example smiling in their company.

Relatives generally spoke positively about the home. For example one told us, "Care is excellent and another one told us, "There is always someone [care workers] around chatting with her." Another relative told us, "Couldn't expect any more."

Health professionals we spoke with; although they raised concerns about some aspects of the service consistently remarked that the home and its staff were kind and caring and treated people with respect.

During observations of care we saw staff treated people kindly with dignity and respect. It was clear the staff and management of the service cared about people. We saw staff speaking to people to give encouragement and praise. Staff were sensitive to people's privacy and dignity. For example one person went to use the toilet and left the door open and staff quickly noticed and went to close the door. We saw where people became anxious staff quickly intervened and used appropriate techniques to divert them.

People looked clean and were well-dressed indicating their personal care needs had been met by staff at the service. We saw some people had blankets over their knees to protect their dignity. We saw people were comfortable around staff and there was a lot of chatter and some laughter. The lounges were warm and comfortable and some people were watching the television.

We saw before carrying out any tasks staff took time to explain to people what they were going to do and checked people were happy for them to proceed. We saw when staff were helping people to transfer using the hoist they gave constant reassurance and kept them informed of what they were doing at each stage of the process. They ensured people's dignity was maintained and were patient and kind with people. After one person had been transferred into their chair they pointed at the staff member and said to us, "She's a lovely girl."

Dignity and respect was monitored through dining experience and dignity audits. We found these systems had been effective in challenging staff practice and helping to ensure interactions between staff and people who used the service were consistently positive.

Improvements to the organisation of the environment, for example the closing of the upstairs 'barn' lounge meant staff were able to more closely monitor and interact with people in more pleasant surroundings. We saw staff were more responsive to people's needs, for example if they became anxious or needed assistance with personal cares.

People and their relatives told us they felt listened to by the service and had their choices respected. We

saw evidence in people's records that choices were better documented.

Care records contained more detailed information on people's life histories and biographies. Care workers we spoke with had a good understanding of the people we asked them about, their likes, dislikes and preferences.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with and their relatives said the service provided appropriate care that responded to their needs.

At the last inspection we had concerns that people's needs were not assessed by the service and appropriate plans of care put in place. As the service had not admitted any new residents since the previous inspection, we were unable to assess whether improvements had been made to the admission assessment process. However we saw new paperwork had been developed which the provider told us would make this process more robust.

We looked at four people's care records and found improvements had been made in some of the records we reviewed. The deputy manager told us they were currently reviewing and updating all the care records, making the care plans more person-centred and providing an 'at a glance' summary at the front of each file so staff could quickly determine the support people required. Two of the care files we looked at had been updated and we found the care plans were more detailed and person-centred. For example, we saw one person's moving and handling care plan contained specific information about how to move the person safely with the hoist, including the type of sling to be used and we saw this happened in practice. For another person we saw detailed wound care plans and review notes showed the dressing regime was being followed. There was also a fact sheet which explained the medical condition which affected this person.

At the last inspection, we saw the service had not been responsive in obtaining professional advice about whether a person should still be having their medicines through a Percutaneous endoscopic gastrostomy (PEG) tube now that food/fluids through the PEG had been discontinued. The service had failed to arrange a meeting to address this issue. At this inspection although further professional advice had been sought, some of this advice differed and the provider had failed to set up a best interest meeting to determine the course of care and treatment in the persons best interests.

The care records showed one person regularly refused meals; advice from the dietician in February 2015 recommended high calorie snacks and drinks between meals and to maintain detailed records of food and fluid intake. We looked at the food charts from 8 – 18 January 2016 which showed a poor dietary intake, we saw food had been offered but declined. We looked at the fluid intake records for a nineteen day period and found on 11 days the person had received fewer than 1000mls of fluid throughout the day. There was no target fluid intake recorded on the charts or detailed in the care plan. 'Water for Health – Hydration Best Practice Toolkit for Hospitals and Healthcare' by the National Ptient Safety Agency and the Royal College of nursing, dated August 2007 states, "A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day". The daily records from 6 January 2016 onwards recorded a poor diet and fluid intake but there was no information to show what action staff had taken in response to this and no evidence of the involvement of other healthcare professionals. There was no care plan to guide staff in how to manage this person's care needs in terms of what action to take if the person consistently refused care and treatment.

This was a breach of regulation 9 (1a&b) (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw staff were more visible and able to respond better to people's individual needs for example ensuring appropriate pressure area relief was provided and providing personal care following continence issues.

Handovers took place between shifts to keep people up-to-date on people's changing needs.

At the last inspection we had concerns that staff were not engaging people in stimulating activities as part of a strategy to meet their social needs. At this inspection we found improvements had been made. The reorganisation of living space within the home meant staff had more time to spend with people. We reviewed records which provided evidence people had been involved in a number of activities provided by both care workers and external visitors. The deputy manager whilst recognising improvements had been made, told us they were now trying to ensure staff recorded a highly level of information about people's daily lives, for example evidence they had supported people to remain independent by allowing them to help out around the home.

People and relatives told us they didn't have any complaints with the service and if they did the management would sort them out promptly. One relative told us "If there are ever any issues we have a word and it's sorted, they are very approachable." We found there were no complaints received since the previous inspection but a number of compliments had been received which were kept by the service so it knew the areas it exceeded expectations.

Inadequate

Is the service well-led?

Our findings

The home had not notified the Commission of all statutory notifications. It had not recognised and reported safeguarding incidents. In addition the home had not notified the Commission of any of the 10 Deprivation of Liberty Safeguards (DoLS) which were in place. We spoke with the management team about their failure to notify the commission of DoLS authorisations, they confirmed this was due to their ignorance of the requirement, but said they would make the notifications without further delay.

Following the previous inspection in July 2015, the provider had appointed a home manager in November 2015 to help improve nursing leadership and oversight. Sadly they had died unexpectedly in early January 2016, which left the home without any nursing oversight. There were only two nurses available to work day shifts, one of these was also the clinical lead. The clinical lead told us due to the lack of nursing staff they were unable to work any supernumerary hours. Whilst the scenario surrounding the manager was sad and unforeseen, we were concerned about the lack of nursing oversight particularly given there were a number of nursing quality issues which needed to be resolved.

Following the last inspection, we saw a number of improvements had been made for example to care plan documentation, documentation of care and activities and the management of nutritional risks. An external consultant had been consulted and we saw evidence that they had met with staff individually and through staff meetings to help make these improvements.

A greater range of audits were undertaken. Regular audits in areas such as pressure area care, nutrition, medication, health and safety, dignity and dining and cleaning were undertaken and we saw these were improved and were routinely identifying and rectifying issues. There was evidence shortfalls were discussed during staff meetings.

Although an external consultant had been appointed by the provider to help improve the service, there was no structured approach to improvement within the service. The provider told us that the consultant's advice had been all verbal and there was no formal action or improvement plan in place. We were concerned that given our findings on this and previous inspections, and the provider telling us that there were still a number of areas that required improvement that the home manager had been working on, this was not formalised into a robust plan.

A number of issues had not been resolved despite the provider stating to us in October 2015 that they would be. This included addressing nursing skill and competency, ensuring robust personal evacuation plans were in place, ensuring compliance with MCA and ensuring risks to people were appropriately managed.

At the previous inspection we raised concerns over the competency of nursing staff. Two health professionals we spoke with at this inspection raised concerns questioning decisions and practice of nursing staff in January 2016. There was a lack of robust systems to assess, monitor and improve the quality of nursing care provided by the home. Although some supervisions and competency checks had been carried out on some of the nursing staff, these were not sufficiently robust to drive improvement within the service.

For example some competency assessments in medicines had been done following the last inspection, but evidence of these were just a letter than stated nurses were signed off as competent in the administration of medicines rather than evidence of a thorough assessment against defined criteria. Basic supervisions had been carried out for nursing staff by the former manager however these were the same format as care staff supervisions and notes were very brief with no evidence of worthwhile and clinical supervision and reflection of practice.

Following a concern from a health professional about poor nursing practice observed in January 2016, although a supervision meeting had been held, documentation showed it had been completed by the deputy manager and provider and an observation of their practice had been completed by the provider who did not hold nursing qualifications. We therefore questioned their competency to assess and evaluate whether the staff members nursing practice was appropriate. We also had concerns that nursing care plans were audited by a non-clinical member of staff. These audits were not sufficiently robust as they did not identify which care plans had been looked at and listed generic rather than specific actions to be addressed.

The provider told us the former manager (a registered nurse) had carried out a range of audits, however these were not available in the home during the inspection. The provider was unsure the exact nature of the audits the manager had been carrying out or the findings, demonstrating a robust system of governance of monitoring action plans and risks was not in place.

One person received their nutritional intake via a PEG. We found conflicting information about this person's feeding regime demonstrating an accurate record of their care was not maintained. A notice displayed in the person's bedroom stated they received a total intake of 2000mls over 24 hours. The feed regime in their care records dated 8 October 2015 stated they received a total intake of 2340mls over 24 hours. The feed regime kept with the PEG record charts stated a total intake of 2290mls over 24 hours. We looked at the PEG feed charts from 14 – 18 January 2015 and saw the total intake they received varied from 2350mls to 2550mls per day. We spoke with the nurse about these discrepancies. They told us the chart in the person's room was wrong and said they would take this down. We checked our calculations with the nurse who agreed the information was conflicting and could not offer any explanation. They said they had not been aware of these discrepancies and agreed to contact the appropriate healthcare professional to clarify the feeding regime. This was of particular concern as we had identified similar issues at our previous inspection.

This was a breach of regulation 17 (1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Annual satisfaction surveys were done. We looked at the results of the 2015 inspection and found they were generally positive. We saw periodic 'resident and relative' meetings were held. We looked at the meeting minutes from the last meeting in October 2015. There was evidence people were listened to and their views made as well as the provider updating the relatives on recent events within the home.

At the last inspection we had concerns that a suitable and accurate dependency tool was not in use. At this inspection, this was still the case, although we did not identify any risks associated with staffing levels, an improved tool was required to robustly assess staff numbers. This would be particularly important should the provider taken on any new residents.