Tudor Bank Limited

Douglas Bank Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

Douglas Bank Nursing Home is situated on the outskirts of Wigan, in a semi-rural setting. The home enjoys panoramic views of scenic countryside and overlooks the picturesque village of Appley Bridge. The home accommodates up to 40 adults, who need help with personal or nursing care needs, including those who are living with dementia. The majority of bedrooms have en-suite facilities and are of single occupancy, although a few double rooms are available for those wishing to share facilities.

At the time of our inspection the manager of the home had been in post for a very short period of time. Therefore, she had not submitted an application to the Care Quality Commission to become the registered manager of Douglas Bank Nursing Home. 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.

This comprehensive inspection was conducted over two days. The first day was unannounced. This was conducted on 23 January 2017. The provider was given short notice of the second day of our inspection, which took place on 1 February 2017.

The last comprehensive inspection of this service was conducted on 22 March 2016, when shortfalls were identified in relation to person centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, receiving and acting on complaints, good governance and staffing. The provider submitted an action plan, as requested. Comments contained in the action plan were considered during this inspection.

At our last inspection on 22 March 2016 we found the provider had not always ensured that the plans of care had been designed to reflect individual needs. Therefore, this area was in need of improvement to ensure that the health and social care needs of people were being appropriately met.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

At this inspection we found that the care plans were not always person centred and did not accurately reflect people's needs. This constituted a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that some risk assessments were not person-centred; as they did not accurately reflect people's current needs.

At our last inspection on 22 March 2016 we found that the provider had not always ensured that people were treated with dignity and respect. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were treated in a proper manner. This was a breach of regulation 10 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area had been completed.

At this inspection we observed two staff members preparing one person to be transferred in the hoist. This process did not promote dignity and respect for the person involved. Therefore, this was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016 we found the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were in agreement with the care and support delivered to them. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 October 2016.

At this inspection we found that consent had not always been obtained before care and treatment was provided. Therefore, this was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016 we found that the premises were not safe throughout and equipment used for providing care or treatment was not always safe for such use. We identified that risks associated with infection control had not always been appropriately assessed, in order to prevent, detect and control the spread of infections. We also found that the provider had not ensured systems were in place for the proper and safe management of medicines. Therefore, these areas were in need of improvement to ensure that people who lived at Douglas Bank were protected from harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed at various times, the latest being 1 January 2017.

At this inspection we found the management of medicines had significantly improved. Therefore, this part of regulation 12 had been appropriately met. However, although some environmental improvements had been made since our last inspection, we still identified many safety concerns, associated with the premises and the provision of care, which presented a risk of potential harm for those who lived at Douglas Bank. Although some improvements had also been made in relation to infection control, further improvements were still needed to the cleanliness of the environment. This constituted a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016 we found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were not unlawfully restricted. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

At this inspection we found that the records of one person showed that they were unable to make safe decisions about their planned care and treatment. However, a mental capacity assessment had not been conducted and there was no evidence available to show that best interest decision meetings had been held, in order to ensure that care and treatment was provided in accordance with the best interests of this person.

The care records for one person, who lived at the home, indicated they were being gently restrained against their will. This represented a deprivation of liberty. There was no evidence to demonstrate that a Deprivation of Liberty Safeguards (DoLS) application had been submitted.

This constituted as a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016 we found the provider had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises. Therefore, this area was in need of improvement to ensure that the services provided were sufficiently assessed and monitored to ensure any areas of risk were identified and mitigated as soon as possible. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area were on-going.

At this inspection we found quality monitoring systems had been implemented, but these were not effective. Some documentation, such as care plans, falls risk assessments, dependency assessments and Personal Emergency Evacuation Plans (PEEPs) did not always reflect people's current needs and some documents, such as dietary and fluid charts, were being inaccurately completed. These failings could have had a detrimental impact on the health and safety of those who lived at the home. Therefore, this constituted a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016 we found that the provider had not ensured the premises throughout were being properly used or properly maintained. Therefore, this area was in need of improvement to ensure that all parts of the home used by residents were suitable for their use. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 26 June 2016.

At this inspection we found that all parts of the home were suitable for the use of the people who lived there. Therefore, regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met on this occasion.

At our last inspection on 22 March 2016 we found that the provider had not ensured an effective system had been implemented for identifying, receiving, recording, handling and responding to complaints. Therefore, this area was in need of improvement to ensure that complaints were being appropriately managed. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area had been completed.

At this inspection we found that complaints were being well managed. Therefore, regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was being met on this occasion.

At our last inspection on 22 March 2016 we found the provider had not always ensured that persons employed had the qualifications, competence, skills and experience which was necessary for the work to be performed by them. Therefore, this area was in need of improvement to ensure that the staff team were sufficiently trained and experienced to deliver the care and treatment required by those who lived at

Douglas Bank. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

At this inspection we found that a good amount of training had been provided for the staff team. Therefore, regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met on this occasion. However, we have made a recommendation in relation to the large amount of training provided in a short space of time and the limited knowledge of staff in relation to the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).
We noted that the provider had not always informed us of significant events, such as serious injuries. For example, we had not been notified of a fall, which resulted in a serious injury and which had a lasting effect on the person concerned. This person's mobility plan of care showed a significant deterioration in their health since the fall in December 2016, which resulted in a serious injury.

This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the Registration Regulations are a breach of the provider's condition of registration.

The home's Statement of Purpose and Service Users' Guide provided obsolete information, as they were last updated in July 2011, but since then several management and staffing changes have taken place. We made a recommendation about this.

The staff team had received training in safeguarding adults and whistle-blowing procedures. Staff members we spoke with were confident in making safeguarding referrals, should the need arise. People who lived at Douglas Bank told us they felt safe being there and we found that the recruitment practices were robust, which helped to protect people from harm. There seemed to be sufficient staff on duty on the days of our inspection and it was observed that staff were always present in the communal areas of the home. However, people told us that there were sometimes shortfalls in the staffing levels at night time. Records showed that although some agency staff were utilised, in order to cover staffing shortfalls, the levels of agency staff usage had decreased since our last inspection.

Social care profiles were in place in each person's care file, which reflected people's preferences and what they liked to do and needs assessments had been conducted before people moved into the home. Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and need for consent.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

This service was not safe.

During the course of our inspection we observed many areas of risk, which did not protect people who lived at the home. The Personal Emergency Evacuation Plans [PEEPs] were not always accurate, which placed people at the risk of harm. Some areas of the home we found to be unsafe and fire safety was an issue.

Although some improvements had been made in relation to infection control since our last inspection, parts of the home could have been cleaner on this occasion.

Records showed that staff had received training in safeguarding policies and whistle-blowing procedures. Staff members we spoke with confirmed this to be accurate and they told us that they would report any concerns they had about the safety of someone who lived at the home, without delay. However, we observed some poor moving and handling techniques.

Recruitment practices adopted by the home were robust and medicines were being well managed.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty and formal consent had not always been obtained from the relevant person.

Staff members we spoke with were aware of the assessed needs of those in their care.

New staff members were guided through an induction programme when they started to work at the home. The staff team received a range of mandatory training modules, as well as training relevant to people's needs.

The new manager of the home was introducing regular supervisions and annual appraisals for all the staff team.

Improvements had been made to the environment for those who lived with dementia.

People had a choice of meals and these looked appetising and nutritious. Those we spoke with told us that they enjoyed the meals served.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The care plans we saw incorporated the importance of privacy, dignity and independence, particularly during the provision of personal care.

We saw some positive interactions and caring approaches towards people who lived at the home. Some choices were offered and individual wishes were often respected.

However, we observed two staff members preparing one person to be transferred in the hoist. This process did not promote dignity and respect for the person involved.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Although assessments of people's needs had been conducted before people moved into the home, we found that plans of care were not always person centred, as they did not consistently reflect individual needs and those who lived at the home had not always been afforded the opportunity to be involved in planning their own care.

Staff interacted with people in a responsive manner and complaints were being well managed.

Is the service well-led?

Inadequate

This service was not well-led.

Everyone we spoke with provided us with positive feedback in relation to the new manager of the home. However, she had only been in post for three weeks. There were a significant number of areas which were unsatisfactory and in need of improvement. These had not been recognised by the provider and therefore a number of breaches of the regulations were identified.

The provider had not always notified us of significant events,

which resulted in serious injury.

Feedback from those who lived at the home, their relatives and staff members was actively sought through surveys and meetings. This allowed the manager to establish how satisfied people were with the quality of service provided.

A range of policies and procedures were available for the staff team, which provided guidance in relation to current legislation and good practice guidelines.

Douglas Bank Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on 23 January 2017 and 1 February 2017 by three Adult Social Care inspectors from the Care Quality Commission (CQC) and an expert by experience. An expert by experience is a person who has experience of the type of service being inspected.

At the time of our inspection of this location, 25 people lived at Douglas Bank. We were able to speak with seven of them and thirteen family members. We also spoke with six members of staff and the manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we 'pathway tracked' the care of six people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records, quality monitoring systems and the personnel records of four staff members.

The provider returned the completed Provider Information Return (PIR), within the requested timeframes. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we conducted a SOFI (Short Observational Focussed Inspection) on the dementia care unit. A SOFI helps us to observe the level of staff interaction provided for a small group of people over short pre-set time frames.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Douglas Bank. We asked seven community professionals for their feedback and we received two responses.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe living at Douglas Bank. Their comments included, "I've never felt unsafe. I use my stick"; "I can use my frame and feel safe getting about with that"; "I feel safe and protected. I love living here." And, "I've got my own little room and there are plenty of people around."

People said they felt comfortable speaking with staff, should they have any concerns. One person told us, "Yes I can speak with staff. If they can't help, they'll find someone who can." And another commented, "Yes, they're very good like that. I can talk to them and they can go to their bosses."

People we spoke with expressed their satisfaction about being able to make choices, in relation to daily living. When asked about staffing levels, comments included, "During the day there's lots of staff. At night, not so many. I don't know how many, but not enough." And, "They (the staff) do their best."

When asked about the cleanliness of the home, people's responses included, "Yes I do think it is clean. You can see for yourself – it [the bedroom] was done this morning"; "They keep it pretty clean." And, "I think it's [the home] cleaned every day."

Relatives we spoke with provided us with varying feedback about safety aspects within the home. One told us, "The dedication of staff keeps [name removed] safe. They're [staff] very nice now. This is the fourth manager since [name removed] has been here." Another described on-going investigations into their relative's recent injury and reported, "Half a dozen accidents have occurred in the last year, one of which was not reported to family or documented at the time." However, this family member was happier with the current staffing levels being provided on the ground floor. They also said, "There's a slippery floor [in bedroom], like lino and [name removed] was just sliding because they can't walk properly now." A third relative described a number of incidents in which their family member was at risk or had been injured. They felt very unsatisfied and concerned about this. We noted this person had a cut and bruising to their face. We advised the new manager to look into the concerns raised.

At our last inspection on 22 March 2016, we found that the premises were not safe throughout and equipment used for providing care or treatment was not always safe for such use. We identified that risks associated with infection control had not always been appropriately assessed, in order to prevent, detect and control the spread of infections. We also found that the provider had not ensured systems were in place for the proper and safe management of medicines. Therefore, these areas were in need of improvement to ensure that people who lived at Douglas Bank were protected from harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed at various times, the latest being 1 January 2017.

At this inspection, we found the management of medicines had significantly improved. Therefore, this part of regulation 12 had been appropriately met.

During the course of this inspection, we toured the premises. Although some environmental improvements had been made since our last inspection, we still identified many safety concerns, associated with the environment, which presented a risk of potential harm for those who lived at Douglas Bank. For example, there were trailing wires from heater extensions in the conservatory, which created a potential trip hazard. There were dead insects and mould on the window blinds. This area of the home was also very cold.

A cupboard upstairs was unlocked. Inside this were archived confidential paper records. This cupboard also contained the electrical switchboard/fuse box. A notice stated: 'Danger 415 volts'. A battery operated illuminated sign had wires hanging from it and no battery cover, making it easy for the batteries to be removed. There were dead insects in all the light fittings in the corridors. There were three uncovered radiators in the corridors. One of these was excessively hot and therefore created a potential safety risk for those who lived at Douglas Bank.

Bedrail checks had been completed each month. However, they simply stated, 'in good working order', 'correctly fitted'. There was no information to show what had been checked, such as bedrail covers and if any gaps, such as at the head of the bed or between the bars had been measured to ensure they were in line with recognised bed rail guidelines.

We saw that a variety of bottles of nail varnish and nail varnish remover were left unattended on a dining table in the dementia care unit. One of the people who lived on this unit was sitting at this table. This did not promote the safety of those who lived on the dementia care unit. There was a lock on the outside facing of one bedroom door, which could have potentially resulted in someone being locked in this bedroom from the outside and the door could not have been opened from the inside. The flooring was uneven, which could have potentially created a trip hazard.

We identified some concerns around fire safety. The fire officer had inspected the home on 31st October 2016, when it was identified that people were at risk in case of fire. The fire officer at that time was reassured that necessary improvements would be made, in order to sustain an adequate level of safety. We looked at fire audits and found these were not robust. Those we saw had not identified the failings we found at the time of our inspection and some were not fit for purpose. For example, the fire door checks just stated, 'Doors checked', but did not indicate what had been checked. We found that one fire door was not fitting into the doorframe properly. Records did not demonstrate that staff members had received appropriate training to complete fire checks within the building. We observed a large plant pot obstructing one fire escape route, which no-one we spoke with was aware of. One of the fire extinguisher boxes was broken and the clips on another were broken. However, these had not been picked up on the fire extinguisher checks done on the day of our inspection. We were told who was responsible for fire safety within the home. However, we were not assured that adequate fire safety training had been provided, as one of these people told us that being responsible for fire safety entailed, "Making sure everything is OK."

On the first day of our inspection, we observed one mobile person sitting on a chair at the end of a corridor. They were smoking and flicking the ash outside the open fire door. This was evidently normal practice. The smell of smoke was permeating into an adjacent occupied bedroom and into the lounge. This fire door when closed was not secure at the bottom, the fire alarm break glass was missing and the glass tube was missing from the fire door. We discussed these concerns with the manager and the maintenance person during the day. We were told that this particular fire door was used by para-medics and delivery personnel and that it would open automatically in the event of the fire alarm sounding, but that a key code system was also in operation. However, none of this information was incorporated into the fire risk assessment. We were also told that a smoking shelter was in the process of being built in the grounds of the home. We were provided with conflicting information about the length of time the break glass had been missing. There was

no risk assessment available around smoking within the home and this was not incorporated into the care planning system. We returned to the home to complete our inspection nine days later and found the same concerns. Although a fire risk assessment was in place and some internal fire checks had been conducted, these failed to highlight the shortfalls we found. Records stated that fire drills must be completed every six months unless a specific risk requires more often. However, a fire drill had not been conducted for eight months. Due to our findings in relation to fire safety, we made a referral to the Lancashire Fire and Rescue service. The provider has subsequently informed us that action was taken to address the shortfalls identified by the fire officer in November 2016.

During the course of our inspection we saw two very unsafe moving and handling manoeuvres, when transferring people from one chair to another. These observations put people at risk of injury and one incident resulted in a person wincing and shouting out, "Ow, you've hurt my hand!" This individual had sustained a cut to their finger. We looked at the plan of care for another person and found that this was not being followed in day to day practice, as instructions were to use an Oxford hoist and a small size sling. We saw two staff members transferring this person in an unsafe manner with the use of a moving and handling belt. The failure to follow the directive set out in the plan of care put this individual at risk of injury. We spoke with three staff members about the availability of moving and handling equipment, to ensure there was sufficient supplied. We were told that the home had three hoists available, plus a stand aid. All three staff felt this was enough equipment with the current occupancy levels.

We observed one person sitting in a wheelchair for long periods of time. There were no footplates in place and therefore this person's feet and legs were unsupported. We spoke with a family member of this person who told us that their relative had a tendency to fall forward due to poor sitting balance. However, there was no lap belt in place on the wheelchair for support and safety. The risk assessment for this person showed a 'very high risk of falls' and the plan of care for falls stated, '[Name removed] is fully mobile unaided and does not require any aid or support.' We also observed one care worker place a person in a wheelchair next to an armchair ready for transfer. The care worker said she would be back 'in a minute' to get them into the armchair. The care worker returned twenty three minutes later. This was discussed with the manager at the time of our inspection. We also observed one person being moved backwards in a reclining chair without any warning. The individual appeared alarmed at this sudden movement.

The risk assessments for one person who lived at the home, in relation to physical aggression and compliance with medicines had been reviewed each month from December 2015. However, the levels of risk had not been identified and therefore the process was incomplete. In relation to medicines, the instructions for staff was to try to help with the medications several times, but if it is still refused then record it as being refused. There were no other strategies in place or any indication that other health care professionals had been involved.

During the course of our inspection, we observed one person, who required the support of two staff members for all transfers. The plan of care, in relation to mobility read, '[Name removed] is bedbound/chair bound since she had recent hospitalisation due to fall and her mobility has deteriorated. [Name removed] requires two staff to assist for repositioning. Requires full body hoist for all transfers. Needs two staff to assist with oxford hoist and small size sling.' However, we observed two staff members transferring this individual with the use of a moving and handling belt. This meant that the care plan was not being followed in day to day practice, which could have had a negative impact on this person's comfort and safety. Other documents within the care file had not been updated since the change in this person's needs. For example, the Personal Emergency Evacuation Plan [PEEP] was dated prior to hospitalisation and stated, 'Mobile, but will need carer to direct to appropriate place of safety'. This could have had an impact on the person's safety, should evacuation by the emergency services have been required. The falls risk assessment had not been

reassessed since the changes in need and this also showed the individual to be fully mobile. The tool used to determine the level of dependency again indicated the person to be mobile without assistance.

We found the provider had not always ensured that safe care and treatment was provided for service users, by assessing the risks to their health and safety and by doing all that was reasonably practicable to mitigate such risks. This constituted a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Dependency assessments had been conducted, which covered areas, such as mobility, dressing, personal hygiene, continence and skin integrity. Some of these showed that people's dependency levels changed and additional measures had been put in place to mitigate risk, such as increased observations.

We saw that cleaning schedules had been introduced and some internal checks were regularly completed, such as legionella, emergency lights and fire alarms. However, some of the checks were not robust, in that those who were responsible for completing them did not have sufficient knowledge to ensure that these were done in a competent manner. For example, we established that the manager of the home and one other member of staff were responsible for fire safety. We discussed fire safety with the identified staff member at length. They told us that they activated the fire alarm to test the system weekly, but that 'the girls' [care workers] checked the fire doors. We asked if the care workers would know if a fire door was not secure. The staff member replied, "No." Also they did not know who had received fire training amongst the staff team, as they did not have access to this information, despite them being responsible for fire safety within the home. We discuss this with the manager at the time of our inspection, who assured us this would be assessed and addressed appropriately.

We found that some improvements had been made in relation to infection control. However, further improvements were still needed to the cleanliness of the environment. For example, one high windowsill on the first floor corridor was very dirty and a screw had been left in this area. Some light switches were dirty and one was broken, which had been covered with sticky tape and a notice attached, which stated, 'Broken. Do not use.' The kitchenette area on the first floor was in need of a thorough clean. The drinks machine was also very dirty. Milk was being stored in a cupboard in this area, instead of the fridge and disinfectant was also noted in this unlocked cupboard.

The food hygiene inspection conducted by the Environmental Health Officer resulted in a level 5, which corresponds with 'very good', the highest level achievable.

During our inspection, we assessed the management of medicines, which we found to be of a satisfactory standard. We saw that a good range of medicine policies and procedures were in place at the home, which provided staff with clear guidance about the safe management of medications. The Medication Administration Records (MAR) were completed appropriately with any refusals or omissions being clearly recorded. As and when required medicines were being administered in accordance with the prescription and controlled drugs were being managed safely. Staff responsible for the administration of medicines had received training in this area and the new manager of the home had introduced competency checks and robust audit controls. People we spoke with felt the management of medicines had improved and now they were receiving their medications on time.

People we spoke with felt there was sufficient staff on during the day, but that at night there could be more. There was adequate numbers of staff on duty on the days of our inspection and we saw staff members were always present within the communal areas of the home. We noted that throughout our inspection staff sat and chatted with people regularly, which was pleasing to see and people did not have long to wait for

assistance with personal care. The staff rotas matched the number of staff on duty and where agency staff were utilised, then this was often the same agency workers, which helped to promote continuity of care. One member of staff told us, "Staff morale has improved a lot."

Staff members we spoke with told us they had undergone training in relation to safeguarding adults and records we saw confirmed this information to be accurate. They were also fully aware of the whistleblowing policies and were confident in reporting any concerns in the most appropriate way. When discussing safeguarding procedures one member of staff told us, "I would go to the person involved, manager or higher, depending on what I saw" and another said, "I have read the policy [Safeguarding]. I would go and see the manager if I had an issue, or the CQC."

Risk assessments were seen, which covered areas, such as pressure care, bed rail safety, moving and handling, nutrition and falling. However, on one occasion we noted that two different systems were being utilised for assessing risks associated with skin integrity. This was confusing and therefore we suggested to the manager that the two methods be amalgamated into one recognised system for easy reference. Body maps were also in place, which identified any areas of bruising or unobserved minor injuries.

Accidents and incidents were documented and these records were retained in line with data protection guidelines. However, there had not been any analysis of the information since July 2016. We discussed this with the manager at the time of our inspection, who accepted improvements were needed in this area and who was fully aware of the need to analyse accidents and incidents, in order to develop a good audit trail and to identify any recurring patterns.

Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were safe for use and protected people from harm. A business continuation policy was in place at the home, which covered emergency contingency plans for events, such as power failure, bomb threat, flood, gas leak, heating loss, severe weather conditions and loss of utilities. On the second day of our inspection, a fire alarm test was conducted, with people being given ample warning of the planned test.

During the course of our inspection, we looked at the personnel records of four people who had worked at Douglas Bank for varying periods of time. We found that recruitment practices for these people were robust, which helped to keep those who lived at the home safe. Each staff member's file contained two written references and Disclosure and Barring Service (DBS) checks. DBS checks highlight if the prospective employee has received any criminal convictions or cautions. This helped the provider to decide if the individual was deemed fit to work with the vulnerable people, who lived at the home. Each applicant had submitted recognised forms of identification. They had also completed health questionnaires and application forms. We spoke with staff about the recruitment procedure, which confirmed that the process was robust and that all necessary checks were conducted before people started to work at the home.

Requires Improvement

Is the service effective?

Our findings

People we spoke with said they enjoyed their meals and they confirmed that staff members got their agreement before providing any care or treatment. One person commented, "They [the staff] know it is okay though, because in the past I've given my permission, so they don't need to ask every time."

In relation to the staff team, responses from those who lived at Douglas Bank included, "They're (the staff) not so bad"; "I think they [the staff] do their best in the circumstances. There are so many people needing such a lot of help, aren't there?" And, "It's tricky sometimes, getting people from A to B, but they're [the staff] very good."

We asked people if they were able to go out, when they wanted to. Comments we received included, "Yes. I go for a smoke outside when I want to"; "Yes. I'd see the people in charge and make arrangements with them [to go out]; "With help, yes. I've been out loads of times [supported by family member usually]." And, "Yes. I'd need somebody to help. They [the staff] walk you."

At our last inspection on 22 March 2016, we found the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were in agreement with the care and support delivered to them. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 October 2016.

At this inspection, we saw some consent forms to be present within the care files we looked at such as, the taking of photographs and the sharing of information. However, records showed that one person whose care we pathway tracked had been placed on 15 minute observations following an incident at the home. However, there was no evidence to show they had consented to this high level of observation.

The care records for one person who lived at Douglas Bank contained a letter from their daughter to the home, which stated that she had discussed end of life care for her mother with her brother and they did not wish for Cardio-Pulmonary Resuscitation [CPR] to be performed. A Do Not Attempt Cardio-Pulmonary Resuscitation [DNACPR] order was in place, dated 19 January 2017, which had been signed by the individual's daughter, but no reason was given as to why this decision had been made. However, it did state that the person had not been consulted, but the decision had been made in their best interest. An advanced care plan discussion form was in the care records. However, this did not indicate discussions had taken place with any health care professionals regarding this decision and there was no evidence available to demonstrate that legal authority had been granted for the daughter to make decisions on their mother's behalf.

One care file we saw indicated that a Lasting Power of Attorney (LPA) had been appointed for health and welfare and therefore consent to certain areas of need had been signed by the designated person. However, we did not see any legal documents on file to demonstrate that an LPA had been approved for the individual

concerned. The care plan for another person in relation to communication instructed senior staff to discuss issues in relation to care and finances with their daughter, who was appointee. However, again there was no legal documentation available to confirm this to be accurate information.

We found that consent had not always been legally obtained before care and treatment was provided. Therefore, this constituted a continuous breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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. We checked whether the service was working within the principles of the MCA.

At our last inspection on 22 March 2016, we found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were not unlawfully restricted. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

At this inspection application for Deprivation of Liberty Safeguard (DoLS) authorisations were seen in several people's care files. However, there were entries in the plans of care, which could have constituted additional DoLS applications being made. For example, the directions in one care plan we saw stated, 'One member of staff to gently hold [name removed] hands to reduce the risk of them hitting out.' This instruction for staff represented a deprivation of the individual's liberty by restraining them. There was no evidence available, in this case to demonstrate that a DoLS application had been made. The Mental Capacity assessment had not been reviewed since this person returned from hospital three weeks previously and there were no records of best interest meetings being held for this person, who was deemed as being unable to make decisions specific about their care and treatment.

We found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty. This constituted a continuous breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 22 March 2016, we found the provider had not always ensured that persons employed had the qualifications, competence, skills and experience which was necessary for the work to be performed by them. Therefore, this area was in need of improvement to ensure that the staff team were sufficiently trained and experienced to deliver the care and treatment required by those who lived at Douglas Bank. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

At this inspection we established that new employees were provided with induction programmes and were issued with a range of information when they first started to work at the home, such as job descriptions and

terms and conditions of employment. These informed them of what was expected whilst working at the home and outlined their duties specific to their individual roles. Staff we spoke with described their induction programme and provided us with some good examples of training they had completed during this period. They felt their induction was sufficient for their needs and helped them to do the job expected of them. One staff member told us that their induction lasted two weeks, during which time they shadowed a more experienced member of staff.

On the second day of our inspection, the tissue viability nurses attended the home, in order to provide some training for staff in relation to pressure care. One member of staff told us they did not receive supervision, but that appraisals were conducted. We saw some supervision records, which were fit for purpose and covered all relevant areas. However, another staff member commented, "The new manager has started doing them [supervisions]. I think she is going to work wonders with the place." One care worker we spoke with felt that new staff could have more training modules to complete.

We found that a good amount of training had been provided for the staff team. Individual training records and certificates of achievement were present in staff members' personnel records. These covered areas, such as moving and handling, safeguarding, infection control, fire awareness, food hygiene, health and safety, dementia awareness, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with gave us some examples of training they had completed, which corresponded with the records we saw.

We were informed and records confirmed that multiple training sessions were delivered on the some days, which questions the depth and quality of training provided, as areas such as health and safety, infection control, safeguarding, the MCA and DoLS are considerably lengthy and comprehensive topics to cover and for staff members to digest. We saw that six topics had been covered on some training days. Staff members we spoke with had limited knowledge of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). We recommend that the provider assesses the provision of internal training programmes to ensure sufficient content and to make certain that staff members training capabilities are not overloaded. We also recommended that the provider considers some additional training for the staff team in the areas of MCA and DoLS.

At our last inspection on 22 March 2016 we found that the provider had not ensured the premises throughout were being properly used or properly maintained. Therefore, this area was in need of improvement to ensure that all parts of the home used by residents were suitable for their use. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 26 June 2016.

At this inspection, we found that all parts of the home were suitable for the use of the people who lived there. However, the floorboards in one bedroom were very noisy, which could have been disturbing for the person who lived in this room.

We found that improvements had been made to the environment on the dementia care unit. For example, memory boxes had been installed; a clear orientation board had been introduced, which displayed important information, such as the date and day. A menu board had also been erected, which clearly showed the menu of the day, highlighted by corresponding picture menus. The handrails on both sides of the corridors were painted in contrasting colours to make them easily recognisable.

Two members of the inspection team assessed the management of meals on each unit. The menus we saw

were on a four weekly rotational basis and offered two choices of each course. Breakfast consisted of a wide range of foods, such as cereals, fruit juices, toast and a full English breakfast for those who wanted it.

Lunch was served in the dining rooms or in the lounge areas. Dining tables were attractively set with tablecloths and cutlery. Seats were comfortable and had arms for support. Several people needed assistance to get to their seats in the dining areas. We saw that people were sitting at the dining tables on the ground floor for some time before being served lunch, although they were given cups of tea whilst they waited.

The main course was served hot and appeared well-balanced and nutritious. One person commented, "By golly. This is delicious" and another said, 'It's lovely. I just wish it would come with the rest [of the people's meals]." A care worker responded to this by saying, "It's because it's a special one [meal] for you and we had to wait until the others are done before we could get yours." There was a choice of sweet, as well as main course. Comments from people in relation to the meals served were generally positive. One person told us, "This morning I rang my buzzer, because I was awake and asked if I could have a cup of tea. They [the staff] brought me one.

We observed a high percentage of people required assistance from staff with their meals. This was provided in a kind and caring manner. Staff members were chatting with people whilst assisting them on an individual basis. We noted that on the dementia care unit people were supported with their meals in a sensitive and discreet manner.

During the course of our inspection, we looked in detail at the care and support of six people who lived at Douglas Bank Nursing Home. We found that a wide range of community professional had been involved in the care and treatment of those who lived at the home. This helped to ensure that people's health care needs were being appropriately met. We saw that a Speech and Language Therapist [SALT] had assessed some people's swallowing reflexes. Soft diets and thickened fluids were in use on their recommendations. Where an external professional had left instructions for the staff team, then these were recorded within the care planning documentation. People we spoke with told us that they were able to see a doctor, if they were not well. One person commented, "Yes, they're [the staff] very good in that respect."

We spoke with a community professional who visited the home whilst we were there. He told us that the knowledge of staff about those who lived at Douglas Bank was variable, in that, some staff members were very knowledgeable, but others were less so. He said that sometimes instructions were not followed in day to day practice and that some staff members were very helpful, but others not so helpful. However, he did not have any major concerns about the home.

We pathway tracked the care and support of one person who was on 'arm's length' observations. This means that they were being observed by one member of staff from a distance, in order to keep them safe and to promote independence. An agency care worker was providing the support for this person on the day of our inspection. We discussed the care of this individual with the agency worker. We established that the carer was deployed by the agency on a full time basis to Douglas Bank, in order to support this person and to provide continuity of care. The agency worker was very knowledgeable about the person he was supporting and he had evidently developed a good working relationship with the individual.

Requires Improvement

Is the service caring?

Our findings

Comments we received from those who lived at Douglas Bank included, "They [the staff] always seem to be dashing off to do the next thing"; "They [the staff] are all right. Nice people – most of them anyway"; "She's [indicating one of the staff] a very caring lady – keeps me amused!" "They knock on the bedroom door and shut it when they go out"; "They treat you with respect, yes." And, "I get given bed baths. They [the staff] keep me covered up properly."

At our last inspection on 22 March 2016, we found that the provider had not always ensured that people were treated with dignity and respect. Therefore, this area was in need of improvement to ensure that people who lived at Douglas Bank were treated in a proper manner. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area had been completed.

At this inspection, we observed two staff members preparing one person to be transferred in the hoist. This process was conducted in a manner, which did not promote gentle handling, dignity or respect for the person. We discussed our observations with the staff involved, the manager of the home and the provider, who confirmed this was not intentional and additional moving and handling training would be provided for staff. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that their independence was, in general promoted and that they could receive visitors in private, should they wished to do so. They also told us that they were offered a variety of choices, such as where they would like to sit, what they wanted to do, what they wanted to wear, whether they wanted to be supported or not and what time they wished to get up.

We observed staff members speaking with people in a kind and respectful manner. It was evident that they had knowledge of individual preferences. Relationships between staff and those who lived at Douglas Bank appeared to be positive.

We saw that those who lived at Douglas Bank looked well-presented and smart in appearance. We saw care workers knocking on people's bedroom doors before entering and supporting people in a warm, pleasant and caring manner, whilst enjoying a chat with those who lived at Douglas Bank.

We noted some good interactions by staff during the course of the day on the dementia care unit. We found this unit to be calm and relaxed with some good diversion techniques being used when one person started to become agitated. However, we spoke with one family, who told us about some remarks made by members of staff towards their loved one, which they found upsetting and disrespectful. We discussed this with the new manager of the home, who advised us that she would speak with this family, in order to look at their concerns.

The care records we saw recorded people's likes, dislikes and leisure interests, as well as their family history.

This helped the staff team to develop a picture of the people who lived at Douglas Bank. The plans of care incorporated the need for privacy, dignity and independence, particularly during the provision of personal care.

Requires Improvement

Is the service responsive?

Our findings

We asked people if their beliefs were respected, whilst living at Douglas Bank. One person replied by saying, "Yes. My priest comes to see me every Friday." Everyone we spoke with expressed their satisfaction about the care and support they received. No-one said they preferred a particular gender of staff member. Their comments included, "I'm happy with whoever comes along. They're all pretty good." And, "I don't mind who gives support."

People we spoke with told us they would know how to make a complaint and would not be fearful in doing so. One relative told us that they kept a constant eye on things and would not hesitate to report concerns and demand resolutions, should this be needed.

At our last inspection on 22 March 2016, we found the provider had not always ensured that the plans of care had been designed to reflect individual needs. Therefore, this area was in need of improvement to ensure that the health and social care needs of people were being appropriately met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 1 January 2017.

Records showed that pre-admission assessments had been conducted before people moved into the home. These covered areas of daily living, such as eating and drinking, falls, personal hygiene, sexuality, socialisation, medication, skin integrity, communication and end of life wishes. This helped the staff team to build a picture of those who lived at the home and to be confident they could provide the care and support required by people, before a placement at Douglas Bank was arranged.

During the course of our inspection, we 'pathway' tracked the care of six people who lived at Douglas Bank Nursing Home. We found that these care records varied in quality. Social care profiles were in place in each person's care file, which detailed their life histories, reflected their preferences and described what they liked to do. Needs assessments had also been conducted before people moved into the home. However, we pathway tracked the care and support of one person, whose needs had significantly changed and found that their care plans had not been fully reviewed and updated to reflect their current circumstances.

Records we saw showed that a wide range of community professionals were involved in the care and support of those who lived at Douglas Bank. This helped to ensure that people's health and social care needs were being appropriately met.

The health care records for one person who lived at Douglas Bank were not reflective of their current needs. The hospital passport for this individual had been developed in 2011, with evidence of only one change in 2015, and the information provided did not describe the care and support being delivered in day to day practice.

At this inspection we found that the care plans were not always person centred and did not accurately

reflect people's needs. This constituted a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans we saw did consider people's preferences and they did contain some good information about people's medical history, which helped the staff team to be aware of individual health care needs. The care file of one person showed that they had a pressure wound and were at risk of falling. Risk assessments were in place for these specific areas of need and relevant plans of care had been developed, which provided staff with clear guidance about how these particular needs were to be best met. Additional supportive documentation had also been introduced, such as body maps and wound charts. This person's records showed that the relevant community professionals had also been involved with this individual's care, such as the GP, Tissue Viability Nurse, dietician, community nurse and falls team.

The care records for another person, who displayed inappropriate behaviour incorporated relevant risk assessments and showed that control measures had been put in place in order to mitigate further risks. Evidence was available to show that this person had been involved in the development of their care plan and had made some decisions about the care and support received.

We spent long periods of time in the communal areas of the home observing the day to day activity. At lunch time on the first day of our inspection one person started asking for her lunch at 12 midday. She repeated her request regularly, but did not receive a response from staff until 12.45pm, when a member of ancillary staff told her that she could not help, as she was not allowed to do so, because she was not a care worker. However, this staff member did approach the kitchen and request the individual's lunch, which was then provided. The person was then able to eat without support from staff.

At our last inspection on 22 March 2016, we found that the provider had not ensured an effective system had been implemented for identifying, receiving, recording, handling and responding to complaints. Therefore, this area was in need of improvement to ensure that complaints were being appropriately managed. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area had been completed.

At this inspection, we found that complaints were being well managed. We noted that a detailed policy in relation to complaints was clearly displayed within the home. This outlined specific time frames to expect within each stage of the complaints process. Contact details for external authorities were also included, should people wish to report concerns to the local authority or Care Quality Commission. A system was in place for the recording of complaints received by Douglas Bank. These had been well managed, with complainants being informed of the outcome of any investigation conducted by the home. Therefore, regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was being met on this occasion.

Records we saw showed that a wide range of community professionals were involved in the care and support of those who lived at Douglas Bank. This helped to ensure that people's health and social care needs were being appropriately met.

We saw a weekly activities programme in the reception area of the home, which included beauty treatments, music, crafts, walking, memory boxes and crosswords. We noted a number of board games, playing cards and knitting accessories dotted around the main lounge, but we did not see these in use. We asked people who lived at the home about the provision of activities and stimulation.

Comments we received included, "I don't really bother. I prefer to watch TV in my own room. There's too much of the same thing on this one [TV in the lounge]. I don't mind word searches and quizzes and stuff, if they are there. When the previous coordinator was here we had trips out, but they've stopped for some reason. This person later told the current activities coordinator that they were, 'fed up with the same old things' on the communal TV. When asked what they would like, they shared views and were told that this could be arranged. Another person told us, "There are some games to play, but one or two seem to have gone missing, or bits missing out of them. I like to read the paper or a magazine."

Other comments we received from people who lived at Douglas Bank and their relatives included, "I go out with my family on trips. I can't see the TV too well but I do watch it sometimes"; "As much as they can with the people involved [provide activities]. Last year they had a few trips out. There's a hairdresser also"; "They tend to do more downstairs than upstairs, I've noticed. They paint people's nails, do colouring and put music on." We saw that one person had been given a doll and evidently enjoyed having this with them at all times. This was handled sensitively at lunchtime, when a staff member needed to move the doll from the table before people sat down. We saw an activity co-ordinator playing a ball game with those who were living with dementia and other staff were sitting with people and chatting. One relative told us that this was not normal. They commented, "They [residents] usually are just left sitting round the sides [of the room], nobody talking." However, the provider subsequently told us, 'This depends on the time of day. Activities go across two floors. It is common for residents to comment that they do not want to talk at certain times.'

Inadequate

Is the service well-led?

Our findings

People we spoke with felt that improvements had been made. One relative said, "Things have changed for the better, with manager and staff changes. There are fewer agency staff now and I see the same faces when I come in most days. I used to be glad when I came and saw one or two particular people, but now, it's of no concern. They're all good." Another commented, "The new manager seems very enthusiastic." Everyone we chatted with spoke positively about the new manager of the home.

On our arrival at Douglas Bank, we noted that the last inspection rating of 'Requires improvement' was clearly displayed in the reception area of the home and also in the manager's office. This information had also been posted on the home's website.

Douglas Bank had experienced regular changes of managers over the previous twelve months, which did not promote stability and continuity of the service. However, the current manager, who had very recently been appointed, demonstrated commitment and enthusiasm to take the service forward and to make the necessary improvements. She was fully aware that she needed to apply for registration with the Care Quality Commission (CQC). She was on duty on both days of our inspection. On our first day of inspection at Douglas Bank, the manager had stepped in to cover a nursing shift, as the registered nurse was on unexpected sick leave.

At the time of our inspection Douglas Bank was in the Quality Improvement Programme (QIP), which meant that they were being supported by outside agencies, such as the local authority, the Clinical Commissioning Group (CCG), the safeguarding team and the Care Quality Commission (CQC) to make improvements needed, as there were concerns about the management of the home. The providers were also visiting Douglas Bank several days per week to offer additional support to the manager and staff team. The providers were on site on the second day of our inspection.

We spoke with a family, who were visiting their relative. They expressed concerns in relation to the general management of the home. They felt that they had not been provided with accurate information about a recent injury, which their loved one had sustained and they told us of inappropriate comments made by some staff members. They were aware of regular management changes and felt this was not promoting a good service. We advised the new manager of the home to discuss the concerns with this family and to decide on a way forward in order to resolve the issues.

During our inspection, we established that a good ancillary support team were in place, which included maintenance and catering staff, laundry and domestic staff, activity co-ordinators and administration support.

Comments we received from staff members included, "I love it here. I love my job. It is like a little family. Everyone here is my mum and dad"; "I know who the owners are. You don't see them that much, as they are busy, but they say 'Hello' to you"; "I feel I am supported by the managerial team now. I wasn't three months ago." And, "Staff morale is a lot better."

At our last inspection on 22 March 2016, we found the provider had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises.

Therefore, this area was in need of improvement to ensure that the services provided were sufficiently assessed and monitored to ensure any areas of risk were identified and mitigated as soon as possible. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in this area were on-going.

At this inspection, we found quality monitoring systems had been implemented, but these were not effective. The monthly auditing system covered areas, such as medication, which advised staff of reporting any medicine errors under safeguarding procedures. However, the medicine audit, conducted in January 2017 had not been fully completed, as the overall score and percentage had not been entered and we could not establish how the results would be calculated. Many of the failings in relation to the safety of the home and the protection of people who lived there had not been identified by the internal auditing systems and therefore we had serious concerns about the monitoring of the home.

There were a range of audits conducted in relation to areas of personal care and activities for individual residents. However, action plans had not always been developed as a result of the findings, in order to provide staff with clear instructions about action they needed to take in order to address shortfalls. Some documentation, such as care plans, falls risk assessments, dependency assessments and Personal Emergency Evacuation Plans [PEEPs] did not always reflect people's current needs.

A family member of one person who lived at the home was visiting on the first morning of our inspection. She confirmed that her relative had been sitting in a wheelchair for one and a half hours. We observed this person was then taken to the dining table in the wheelchair, in which they remained throughout lunch. Lunch was served for this individual, but it was refused. No further exploration was made, as to why the individual did not want the lunch provided and no alternative was offered. A staff member returned the meal to the kitchen and told the catering staff that the person did not want their lunch, but that she would try them again in half an hour, which would have been 1.15pm. This person was not offered lunch later in the day, but was provided with some cake during the afternoon tea round at 3pm. We looked at this person's dietary and fluid intake chart, which showed that at lunch time on the day of our inspection the person had eaten, 'Pureed mash, meat, veg and gravy, chocolate mousse and 200mls of tea.' This is not what we observed. We asked a member of staff what this person had eaten at lunch time and we were told, "[Name removed] had one mouthful of lunch, but didn't have the mousse. They had one mouthful of tea and then knocked it over." We asked what this person had eaten for breakfast and again this information did not correspond with the diet and fluid chart. Therefore, the recording of dietary and fluid intake was inaccurate.

We looked at this person's care records and found that the MUST score, used to establish the level of risk of malnutrition had last been reviewed on 5 April 2016. The risk assessment for malnutrition had not been reviewed since 24 December 2016. This read, 'Daily intake to be monitored' and 'Weight to be monitored', although the frequency of weight monitoring was not recorded. One care worker told us that this person should be weighed weekly. However, records showed that they were last weighed on 20 December 2016, five weeks previously. This recorded weight was prior to their deterioration in health and a change in their diet. An entry in the daily report for 21 January 2017 read, 'Refused supper' and on 22 January 2017 these records stated, 'Poor dietary intake'. Several entries stated, 'Fluids pushed', but the daily fluid intake record showed that insufficient amounts of fluid were taken. However, nothing was recorded in relation to action that needed to be taken, in order to maintain good nutrition and hydration for this person. We discussed our

findings, in relation to poor record keeping with two care workers, who agreed that this presented some issues for the health and well-being of the individual concerned.

These failings could have had a detrimental impact on the health and safety of those who lived at Douglas Bank. It was clear that the assessment and monitoring systems in operation at the home were not consistently effective, as they had failed to identify areas in need of improvement, which the inspectors noted during their comprehensive inspection. The manager of the home agreed that the audit format was not particularly useful.

We found that the provider had not established and operated effective systems, in order to assess, monitor and improve the quality and safety of services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises. This constituted a continuous breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the provider had not always informed us of significant events, such as serious injuries. For example, we had not been notified of a fall, which resulted in a serious injury and which had a lasting effect on the person concerned. This person's mobility plan of care showed a significant deterioration in their health since the fall in December 2016, which resulted in a serious injury.

This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the Registration Regulations are a breach of the provider's condition of registration.

We read the home's Statement of Purpose and Service Users' Guide. Both of these documents were out of date and therefore did not provide current information about the services and facilities available to those who lived at Douglas Bank. It is recommended that these documents be updated to reflect current guidance, as they were last updated in July 2011, but since then several management and staffing changes have taken place.

We saw that surveys for those who lived at the home had been conducted in December 2016. This helped the management team to seek people's views about various aspects of life at Douglas Bank. The main issues raised were in relation to regular changes of management, and continued use of agency staff, lack of activities, insufficient working hoists and erection of a smoking shelter.

We saw that notices were displayed in the home, which invited those who lived there and their family members to attend forthcoming meetings arranged by the manager. This would allow people the opportunity to discuss various topics in an open forum, should they wish to do so. The manager of the home also told us that she intended to hold regular meetings with the staff team, so that any important information could be disseminated throughout the workforce. This would enable those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes. We saw recorded minutes of meetings for staff and heads of care, which outlined some of the shortfalls we identified during our inspection. The new manager of the home was in the process of addressing some of the areas which needed improvement.

We saw there were a wide range of written policies and procedures within the home such as, health and safety, whistleblowing, safeguarding adults, infection control, advocacy and discipline and grievance. This helped the provider to ensure the staff team were kept up to date with current legislation and good practice guidelines.

We spoke with two community professionals during our inspection, who were providing support to one person who lived at Douglas Bank. They told us that they felt the home did listen to them and acted upon their advice. However, they did comment about the number of different managers and senior staff there had been recently, but they felt that the current workforce was competent and that the care staff had good continuity. Their comments included, "We visit the home when issues arise"; "We aren't here regularly, but when we do come, it is friendly and there are good interactions between staff and people who live here"; "The atmosphere is always good"; "The rooms we have been in are comfortable" and "We don't get called out for many pressure sores here."