Latham Lodge Limited

St Wilfrid's Hall Nursing Home

Inspection report

Foundry Lane
Halton On Lune
Lancaster
Lancashire
LA2 6LT

Tel: 01524811229
Website: www.caringhomes.org

Date of inspection visit:
13 June 2018
14 June 2018
18 June 2018
19 June 2018

Date of publication:
02 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Wilfrid's Hall Nursing Home was inspected on the 13,14,18 and 19 June 2018 and the first day of the inspection was unannounced. St Wilfrid's Hall Nursing Home is registered to provide personal care for up to 41 older people who require support with personal care. At the time of the inspection there were 31 people receiving support.

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

St Wilfrid's Nursing Home is situated in the small village of Halton-on-Lune, just north of Lancaster. The home has many historic features and is set in its own extensive grounds. Accommodation is provided on the ground and first floors. There are three lounges, a separate dining room, plus additional seating areas in the hall and on the first floor landing. The bedrooms all have a wash basin, with the majority having en-suite facility of a toilet and hand wash basin.

At the time of the inspection there was no manager who was registered with the Care Quality Commission (CQC). There was an interim manager who was supported by senior management. We were informed by senior management and the interim manager that a manager had been appointed and they were awaiting their recruitment checks to be completed. They explained it was intended that the newly recruited manager would apply to the CQC to become the registered manager.

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.

The inspection was prompted by information of concern that people who lived at the home were not supported safely, staffing was not arranged to meet people's needs and equipment was not available to prepare meals. In addition, we were informed there was no hot water in some bedrooms, paperwork was not always up to date and people had no toiletries to use.

We also used this inspection to check improvements had been made since our inspection in August 2017. At our last inspection in August 2017 we found two breaches of regulation. Staffing levels at the home were not sufficient to provide support people required and people were not always supported safely. We issued Requirement Notices for these breaches in Regulation. We also noted improvements were required in the safe management of medicines. We made a recommendation about this. The service was rated as Requires Improvement.

Following the inspection in August 2107 we asked the registered provider to take action to make

improvements for the areas we had noted. The registered provider was required to send the CQC an action plan, outlining how they intended to make improvements. This was not provided to us.

At this inspection in June 2018 we found people were not always supported in a safe way. Two people had had accidents as a result of staff not following safe moving and handling guidelines. We noted equipment was not always used safely to support people's skin health and staff did not report when people had not reached their individual fluid targets. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us they had to wait for support if they asked for help. We observed this during the first day of the inspection. We timed call bells and found these were not always answered quickly. Relatives told us their family members sometimes had to wait for support and staff told us they did not always have time to respond to people quickly. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Documentation was not consistently reflective of people's needs. Care plans did not always contain accurate information to enable staff to give person centred care. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. We noted one person had their medicines after they had food. This was in contradiction to the medicines instructions which said they should have their medicine a specific time before food was given. Medicine administration records (MAR) were not always an accurate reflection of a person's medicine and a barrier cream was not available for a person to use. In addition, we noted a person's medicine total on a MAR record did not match the total of medicine left and fridge temperatures were not consistently monitored. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always protected from inappropriate response from staff. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always lawfully restricted of their liberty. We noted some people without mental capacity used equipment to maintain their safety. Applications to lawfully deprive people of their liberty had not been submitted to the Lancashire Local Authority in a timely way. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at recruitment records. We found one prospective staff member had gaps in their employment. There was no record to show this had been discussed with them and the reasons for them leaving their last place of employ had been explored. We also saw the previous manager for St Wilfrid's had provided them with a reference as they had worked with them at their previous place of employ. This was not a previous employers reference and there was no risk assessment to show how any risks were to be managed. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care planning had not always been carried out to ensure people's needs and preferences were met. People could not be assured their individual preferences were recorded or that care planning would take place to help them live with behaviours which may challenge. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Audits and checks carried out at St Wilfrid's Hall Nursing Home had not identified some of the issues we identified on inspection. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated

Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

We discussed our concerns with the interim manager and operational director. They took swift action to address the concerns we had identified. Staffing was increased, additional audits were carried out and we were informed investigations would be carried out where this was appropriate.

Staff told us they were supported to attend training to maintain and increase their skills. During the inspection we saw training was taking place. We spoke with the regional trainer who confirmed there was a training plan to ensure staff skills were developed. We have made a recommendation about the training at the home.

We received mixed feedback on the food provision at the home. Some people told us they felt it could be improved. Other people told us they liked it. Everyone told us they had a choice of meals to choose from and we saw people were offered more if they wanted it. We saw people were given the meal of their choice and staff were available to help people if they needed support. There was equipment available to cook meals.

We found the environment was clean and we observed staff wearing protective clothing when required. This minimised the risk and spread of infection. There was hot water available in all areas of the home and people had individual toiletries in their private bedrooms.

Staff spoke fondly of the people they supported and said they wanted to enable people to live a happy life. We observed moving and handling techniques and saw these were carried out with patience and compassion. People were not rushed and staff offered reassurance as they supported people.

Relatives told us they were consulted and involved in their family members care, however this was sometimes led by them. People we spoke with confirmed they were involved in their care planning if they wished to be.

People told us they had access to healthcare professionals and their healthcare needs were met. Documentation we viewed showed people were supported to access further healthcare advice if this was appropriate. People and relatives told us they were happy with the care provided at St Wilfrid's Hall Nursing Home.

There were meetings held for relatives to raise any concerns or compliments and express their views. Surveys were offered to people to capture their views on aspects of the service provided.

Staff told us they were committed to protecting people at the home from abuse and would raise any concerns with the registered manager or the Lancashire Safeguarding Authorities so people were protected.

There was a complaints procedure which was used in practice to investigate people's complaints. People we spoke with told us they had no complaints, but they if they did these would be raised to the interim manager or staff.

There was documentation to record people's end of life wishes. We spoke with one person who confirmed they had been given the opportunity to discuss this, however they had decided they did not wish to do so.

People's privacy and dignity was protected when they received personal care. We observed staff knocking

on doors and bathroom doors were closed when people were supported.

People told us there were a range of activities provided to take part in if they wished to do so. There was an activities schedule was displayed at the service and staff told us they reminded people of the activities available. We observed activities taking place and saw these were enjoyed by the people who participated.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not always receive care and support in a safe way.

Care records were not always an accurate reflection of people's needs.

People did not always receive their medicines when they needed them and in a safe way.

Staff were not always recruited safely and staffing was not sufficient arranged to enable people's needs to be met promptly.

Staff were able to explain the action they would take to safeguard people from abuse and told us they would do so to protect people.

Is the service effective?

Requires Improvement

Applications to deprive people of their liberty were not always made in a timely way to ensure deprivations were lawful.

People could not be assured their hydration needs would be met

People were supported to seek further professional medical advice if this was required.

Staff received training and supervision to enable them to deliver care and support which met people's needs.

People were able to select meals from a menu and told us they had choice.

Is the service caring?

Requires Improvement

The service was not always Caring.

People were not always protected from inappropriate behaviour.

Individual care planning was not consistently carried out to document people's beliefs and faiths.

People and relatives told us some staff were caring.

We saw people's privacy was respected.

Staff spoke fondly of the people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

Care planning was not always carried out to support the delivery of responsive care.

People and relatives told us they were involved in their care and that of their loved one.

People were supported to take part in activities which were meaningful to them.

There was a complaints procedure at the home to ensure people's complaints could be reported and addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits had not identified all the areas of concerns we had noted.

Staff were able to explain their roles and responsibilities and told us they were hopeful changes would be made to improve the service.

People who lived at the home, staff and relatives told us they could talk to the interim manager if they wished to do so.

The registered provider sought feedback from people to improve the service provided.

St Wilfrid's Hall Nursing Home

Detailed findings

Background to this inspection

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

The inspection visit took place on the 13, 14, 18 and 19 June 2018 and the first day was unannounced. On the first day the inspection was carried out by two adult social care inspectors. The second day was announced and carried out by two adult social care inspectors. The third and fourth day was carried out by one adult social care inspector and both days were announced. At the time of the inspection there were 30 people living at the home.

Before our inspection visit we reviewed the information we held on St Wilfrid's Hall Nursing Home. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who received support. As this inspection was carried out in response to information of concern, we did not request a Provider Information Return (PIR.) This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at minutes of meetings held between St Wilfrid's Hall Nursing Home, the local authority and clinical commissioning groups. We used all information gained to help plan our inspection.

We spoke with six people who received support, and five relatives. We also spoke with 10 care staff, the interim manager and the regional manager. In addition, we spoke with the cook, the operations director, the regional trainer and the regional maintenance person. As part of the inspection we spoke with the deputy manager, a qualified nurse and a peripatetic manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records of eight people who lived at St Wilfrid's Hall Nursing Home and a sample of medicine and administration records. We also viewed a training matrix and the recruitment records of four staff. We looked at records relating to the management of the service. For example, we viewed records of checks carried out by the interim manager, accident records and health and safety certification. We also viewed audits carried out by the senior management team.

Requires Improvement

Is the service safe?

Our findings

At the last inspection carried out in August 2017 we identified a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We found people were not always supported safely.

We asked people if they felt safe at St Wilfrid's Hall Nursing Home. People told us, "Yes, I'm safe." And, "Of course I'm safe." Relatives we spoke with told us they had no concerns with their family member's safety. One relative commented, "Never seen anything to worry me here."

Although people told us they felt safe, at this inspection in June 2018 we found two people had experienced accidents. This was as safe moving and handling practices had not been followed. One person had been supported by a single member of staff when the care record indicated two staff members were required. We noted a further person had experienced an accident when their equipment was not used safely. We viewed an investigation report completed by the registered provider which identified the errors which had occurred. We also viewed an accident form which showed equipment had not been used safely.

We reviewed a person's care plan and saw they required a specialist mattress to maintain their skin integrity and reduce the risk of skin damage occurring. We looked at the equipment and saw it was set incorrectly. The mattress was set at a weight heavier than the person's last recorded weight. This posed the risk that the person's skin integrity would be compromised. We spoke with the interim manager about this. They told us the mattress should be set to the correct setting for the person's weight.

The above demonstrated breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as equipment was not always used safely and care and treatment was not always provided in a safe way.

Prior to the inspection concluding we saw the person's specialist mattress was set correctly. The interim manager advised us that an audit of all specialist mattresses in use was being carried out to check they were set correctly.

At the last inspection in August 2017 we identified a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. In August 2017 the staffing levels were not sufficient to provide support people required. Prior to this inspection we had received information of concern that staffing arrangements were insufficient to provide help to people promptly when they required it.

At this inspection in June 2018, we asked people at the home their views on the staffing levels. People told us they felt these needed improving. One person told us, "The staffing is severely lacking." Another person told us, "If I press my buzzer, if I'm lucky someone will come within 20 minutes." A further person said, "If you call your buzzer it can take up to 30 minutes to answer." Of the relatives we spoke with two relatives told us they had no concerns with the staffing arrangements. Other relatives told us they felt more staff were required as staff were often busy.

Staff we spoke with told us they felt more staff were required. We were told, "We could do with a few more staff, we get really busy." A further staff member said, "Sometimes there's so much at one time, it's difficult to prioritise." Staff told us they did not have time to sit with people as they were delivering support and they did not have time to complete documentation or read care plans as they were busy. On the first day of the inspection we found call bells were not answered promptly when people rang for help. For example, we timed a call bell and saw this was answered after 16 minutes.

We observed lounges were not always attended when people were present within them. We saw one person shouting for help. We spoke with the person and arranged for them to receive support. We witnessed a person banging their cup on a table, there were no staff in the vicinity to go to them and ask if they wanted help. We overheard a staff member tell a person who lived at the home they could not help them straight away as they were busy. We observed a person calling for support with personal care. Staff told them they would have to wait as they were busy. A relative asked for help for their family member. They were told by staff they were busy.

Our observations and the feedback we received indicated people did not have always have their needs met in a timely way.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as staffing arrangements did not allow people's needs to be answered promptly.
We discussed our observations and the feedback we had received with the interim manager. They told us they would relay these to the operations director who was visiting the home the next day. On the second day of the inspection we met with the interim manager and the operations director. The operational director explained that staff required support and direction to enable them to work efficiently. They responded swiftly to our concerns by introducing additional staff and staff to offer direction and guidance. They told us they would monitor this and would review staffing arrangements as staff efficiency increased. On the second, third and fourth days of the inspection we found call bells were answered quickly and people were helped when they requested or needed support. We observed staff sitting with people in the lounge area talking with people and completing documentation.

Care records were not always an accurate reflection of people's needs and did not consistently contain accurate information. In one care record we saw recorded the person was to be offered a shower. We spoke with the person who told us this was not accurate as they were currently having a strip wash or bed bath. Staff we spoke with confirmed this.

In the same care record, we noted the person required equipment to help them maintain their continence. There was no information to guide staff on the specific support the person needed and how this was to be delivered. The person told us they used bedrails to maintain their safety when they were in bed and staff we spoke with confirmed these were used. There was no instruction in the care plans we viewed that this was required to maintain the person's safety.

In a further care plan, we saw recorded the support a person required with mobility. For example from sitting to standing. We spoke with the person who told us they could not stand. Staff we spoke with confirmed this.

In a third care record we saw conflicting information was present. One part of the care record instructed a person required a soft diet, another part instructed small vegetables to be liquidised. We also noted the person's Malnutrition Universal Screening Tool (MUST) was wrongly calculated. MUST is a tool used to establish nutritional risk. It had been calculated over one month, rather than three. This meant the record

was inaccurate.

Prior to the inspection we received information of concern to say people were not always supported to change position to maintain their comfort and skin health. We viewed a sample of positional change charts. These are records which record the support people have to help them move position if they are unable to do this themselves.

On one chart we saw there was no entry to indicate the person had received support. We spoke with the person who told us staff did support them. They said, "They don't always fill that in." Staff we spoke with confirmed they did not always complete documentation and people were helped to change position in accordance with their assessed needs.

We looked at wound booklets. These are used to record the treatment given if a person needs wound care. We looked at one booklet and saw the dressing was to be changed daily. There was no record on the following three days to indicate this had been done. In another wound booklet we saw a further entry which instructed the date a dressing should be changed. There was no entry in the booklet we viewed to record this had been done. Staff we spoke with told us the wound booklets were used to record the care and treatment given.

In addition, we saw the wound care protocol indicated the size of wounds should be recorded. In one booklet we viewed we saw two entries where these were not entered in the booklet and there was no photograph to indicate the size of the wound. We reviewed the earliest and most recent photograph of a person's wounds and saw these showed improvements in the person's skin integrity. This indicated treatment was being given as required.

The concerns we identified within the documentation we viewed were breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as records were not always contemporaneous, or an accurate reflection of the care given, or the support people required.

Staff we spoke with were able to describe people's individual needs and the help and support they required maintain their safety and well-being. For example, staff could explain the support people needed to maintain their skin integrity and safety when mobilising. This meant people were supported by staff who knew their individual needs.

Prior to the inspection we received information of concern that some medicines were not always available. During the inspection we found medicines were not always managed safely. We noted one person required their medicines at a specific time before food in accordance with the medicines instructions. The medicine had not been given before food. We spoke with the qualified member of staff who acknowledged this should have been administered prior to their breakfast in accordance with the medicines instructions.

We observed one person was given their prescribed supplement drink by the administering staff. The person responded by saying they already had one in their handbag. We saw the medicine was unopened and had the person's name on it. We looked at the MAR chart for the person and saw the medicine was last given the night before. This indicated the person had not taken their medicine as prescribed. In addition, we found a further person who should have had their medicine administered early in the morning had not received them. We observed staff sought professional medical advice regarding this.

Medicine administration records (MAR) were not always an accurate reflection of a person's medicine. One person had been prescribed a medicine and this was not entered on the person's individual MAR record. We

found a further two people who lived at the home had medicines prescribed which were not recorded on their MAR. Staff we spoke with were unsure if the medicines had been discontinued and not destroyed.

In addition, we noted a further person's medicine total on a MAR record did not match the total of medicine left. The MAR record indicated 34 tablets should be left and there were 32 remaining when we checked by counting the tablets. We also found a barrier cream was not available to be administered to a person. We checked medicines were stored safely and noted fridge temperatures were not consistently monitored to ensure medicines were kept at their optimum temperature.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as medicines were not always managed safely.

We discussed this with the interim manager who told us they planned to investigate these areas and would be carrying out an audit of the medicines at the home. Prior to the inspection concluding they confirmed the barrier cream was available for the person.

We viewed documentation which demonstrated prospective staff were not always recruited safely. We saw no documentary evidence to demonstrate a staff member had had their reason for leaving their previous role explored. There was also no documentation to show a gap in the staff member's employment history had been discussed. Furthermore, the reference provided was from the previous manager of St Wilfrid's Hall Nursing Home as they had worked together at their last place of employ. There was no evidence to show the lack of recruitment information had been discussed to identify risk and a risk assessment carried out to minimise this.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as staff were not always safely recruited.

On the second, third and fourth day of the inspection we saw more staff were available and could meet people's needs promptly. We timed a call bell and saw this was answered almost immediately. We observed staff sitting with people in the lounge area talking with people and completing documentation.

The interim manager told us they were currently recruiting staff. They explained they were in the process of employing a further qualified nurse and they were recruiting for a further qualified nurse. They said it was important to them people were supported by staff who knew them and that permanently recruited staff fostered teamwork and supportive practice. This showed the interim manager recognised the importance of a stable workforce to ensure consistency of care and develop positive working relationships.

We looked at how accidents and incidents were being managed at the home. Staff told us and we saw accident forms were completed. The interim manager told us all falls and accidents were monitored by them for trends and senior management also reviewed accidents and incidents to identify trends. We saw evidence if an accident occurred, action was taken to minimise the risk of reoccurrence. For example, we saw evidence which showed staff had received instruction and guidance on the safe use of equipment. This was following an incident where a person had experienced an accident when equipment was not used correctly. Staff we spoke with were able to explain the instruction they had been given, demonstrate safe practice to an inspector and also explain the importance of why equipment should be used correctly. This showed the registered provider acted to minimise the risk of reoccurrence.

Staff told us they were committed to protecting people from abuse. One staff member said, "Reporting is part of my job. I'd go straight to the office." Staff said they would report any safeguarding concerns to the

registered manager, the registered provider or to the Lancashire safeguarding authorities if this was required.

Staff explained what they would report to ensure people were safe. For example, staff told us they would report unexplained bruising, falls with injury or allegations of abuse to ensure people were protected. One staff commented, "I'd report to CQC, the manager and social services. It's my job." We saw the home had a safeguarding procedure to guide staff and the contact number was displayed on a notice board within the home.

We walked around the home to see if it was a safe place to live. The home was warm and clean with restrictors on windows where people may fall from them. Restrictors help prevent falls from height and minimise the risk of harm. Staff told us, and we saw protective clothing was provided if this was needed. Staff wore protective clothing such as gloves and aprons if these were required. This helps minimise the risk and spread of infection. We noted the home had been awarded a five-star rating following their last inspection by the Food Standards Agency (FSA.) This graded the home as 'very good' in relation to meeting food safety standards about cleanliness, food preparation and associated recordkeeping.

We saw checks were carried out to ensure the risk of legionella was minimised and water temperatures were monitored to ensure people were not at risk from scalds. We viewed a range of health and safety certification. We found equipment was checked for its suitability and safety. A fire risk assessment had been completed and staff we spoke with were knowledgeable of the support people required to evacuate the building if this was required. We noted a fire door was secured by a coded key pad. We asked a staff member if they knew the code to it and they said they didn't as they were not permanently employed. The interim manager told us they would address this as it had previously been highlighted. We passed this information to the Lancashire Fire and Rescue Services so the home could obtain expert advice.

Requires Improvement

Is the service effective?

Our findings

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at how the home gained people's consent to care and treatment in line with the MCA. We asked three people if they were involved in decision making and discussions about their care and if they consented to the support they received. They told us they were consulted and consent was gained prior to care being delivered. However, we found if people lacked the mental capacity to consent to their care, restrictions were not always made lawfully. For example, we saw two individuals at the home had bedrails in use on their beds. These are used to minimise the risk of falls from a bed. Staff told us the individuals did not have mental capacity and the bedrails were used to maintain their safety. We looked at the care records for each person. In one persons file we found an application to lawfully deprive the person of their liberty had been submitted to the Lancashire Local Authority and authorised. We noted this had expired as it was past the date for reapplication. In the second person's file we saw no application to the Lancashire Local Authority had been made. We checked a folder provided to us by the interim manager as we were informed this contained completed DoLS applications. There were no further DoLS applications relating to the people we had identified. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as people who used the service were not lawfully deprived of their liberty.

We discussed this with the interim manager. They told us an audit would be carried out to identify if there were any other people at the home who were being unlawfully deprived of their liberty. Prior to the inspection concluding, they wrote to us and told us DoLS applications to Lancashire Local Authority were being completed.

During the inspection we checked to see if the catering arrangements were sufficient and people's hydration needs were met. This was as we had received information of concern.

We reviewed documentation which recorded the meals and drinks people had. We found people were assessed to ascertain their individual fluid targets. We viewed one chart and saw a person was not meeting their individual targets. We saw their target was 1360 mls and they had drunk 830 mls. On a separate day we saw they had drunk 830 mls. On a further person's fluid chart, we saw recorded the person had drunk 680 mls of fluid. Their individual target was 1043 mls. We discussed this with the qualified nurse. They told us night staff were responsible for totalling up the amount of fluid people drank, and if there were any concerns, this should be handed over to the day staff. They said they had never been informed of any

concerns. The interim manager explained team leaders at the home were responsible for checking the charts were completed during the day.

We spoke with a team leader who told us they checked for entries on the form but did not total the amount people had drunk. The qualified nurse explained the totals were important as adequate hydration minimised the risk of infection, skin damage and avoidable health issues. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider had not done all that was reasonably practicable to minimise the risk of avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to the inspection we had received information of concern that there was no oven at the home. We visited the kitchen and saw the main catering oven was not functioning as it required repair. There was a smaller alternative oven in use and the cook explained this was being repaired, however they were waiting for parts. They said in the meantime, they were buying some meals into the home and preparing some meals at the home.

We received mixed feedback regarding the meals provided at the home. One person told us they did not like the food. Other people we spoke with told us they did. One person commented, "Foods ok." We saw a menu which was varied and people told us they could have alternatives if they requested. We observed people were offered a choice of meals and of where they wanted to eat their meal. We saw people were supported to eat. For example, we saw one person was supported to eat their meal in their room. Another person needed help to cut their food up. This was provided.

We saw evidence people's nutritional needs were monitored. People were weighed to identify if they required further health professional advice to meet their nutritional needs. Staff told us they would support people to gain further professional advice if this was required and they encouraged people to eat and drink sufficient to meet their needs. During the inspection we saw people were offered hot and cold drinks between meals and fruit and biscuits were available. We observed people were able to select what they wanted to eat and people were offered extra if they ate what they had chosen.

Staff told us they received training to enable them to update and maintain their skills. All the staff we spoke with told us they could attend training. One staff member told us they had not received a supervision. This is a meeting held with a person's line manager to discuss performance and cascade knowledge. We passed this to the interim manager for their consideration.

During the inspection we saw training taking place. The operations director told us they had previously carried out a review of training and had identified staff would benefit from increased training to raise their skills. As a result, they had arranged for the regional trainer to be at the home for four days a week to deliver face to face training. We met with the regional trainer who confirmed this. We spoke with qualified nurses and asked them if they had received training in clinical skills such as wound care and catheter care. They confirmed they had. We asked to see documentation which evidenced this, but this was not provided.

We looked at the arrangements for agency staff to receive and induction. We were told all agency staff were inducted to the home. We asked to see evidence of completed agency inductions, but these were not provided.

We viewed a staff training matrix and saw this recorded the training staff had completed. We saw there were gaps in some areas which we discussed with the regional trainer. The regional trainer showed us an action plan which demonstrated training was ongoing. Staff we spoke with confirmed they were expected to

attend training to maintain and update their skills.

We recommend the service seeks and implements best practice guidance in the scheduling and embedding of training and development activities.

People told us they felt the care provided met their needs. One person told us, "Overall I'm looked after." A further person said, "The care is ok." Relatives told us they felt the care was adequate.

Documentation showed people received professional health advice when this was required and their needs were assessed to inform care planning and referrals to other health professionals. For example, we saw assessments in mobility, nutrition and falls risk assessments. We saw documentation which evidenced people were referred to doctors, Speech and Language Therapists and district nurses if this was required. Staff we spoke with were knowledgeable of the individual needs of the people they supported.

We asked staff what documentation was provided to support effective decision making by other health professionals if people needed to attend a hospital in an emergency. We were told transfer forms were used. These were completed at the time of a person's admission to hospital. Staff we spoke with said this was a concern to them as if an agency staff was on duty, they may be unfamiliar with a person's needs and essential information may not be transferred. We discussed this with the interim manager who told us they would look into this.

We asked the interim manager how they obtained and implemented information on best practice guidance and legislation. They told us they were supported by the registered provider who cascaded relevant information to them and in addition when the newly recruited manager started, it was an expectation they would attend best practice events when these were available. This showed the registered provider sought opportunities to learn new guidance and information.

The registered provider used technology to support people. During the inspection we saw an individual pager was being trialled. The interim manager and operations director explained this was so an individual would have a familiar and consistent staff response when they used their call bell for help.

Prior to the inspection we received information of concern there was no hot water in some bedrooms. We checked to see if this was the case. We found hot water was available and people we spoke with raised no concerns. We noted the home required decoration in some areas. We saw the corridor walls were marked and scuffed in some areas and the carpet on the stairs was threadbare on the edges of some steps. We discussed this with the operations director, they told us they had identified this through an audit and this was being addressed. We met with the regional maintenance person who told us they were at the home to carry out decoration. We saw one private room was in the process of being refurbished. This demonstrated the registered provider was in the process of improving the environment.

Requires Improvement

Is the service caring?

Our findings

During the inspection we witnessed an occurrence when a member of staff behaved inappropriately when a person who lived at the home asked for help. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as a person at the service was subject to behaviour which was degrading and their needs were disregarded.

We informed the interim manager of this. They took swift action to ensure the person was supported and people at the home were not placed at risk of a reoccurrence.

We saw care records had areas for people to record their spiritual and cultural beliefs. We looked at one care plan and saw this had no person-centred information recorded. We spoke with the person who told us they had not been asked if they had any beliefs or faiths they wanted to follow. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider had not carried out collaboratively an assessment of the needs and preferences of the person and designed care and treatment to achieve the person's preferences.

Some people who lived at the home told us staff were caring. Comments we received included, "Their approach to me is very good." Also, "The staff are so lovely. They look after me." However, two people told us some staff had been abrupt with them. We discussed this with the interim manager and were informed customer care training would be introduced to address this.

Staff spoke affectionately of people who lived at St Wilfrid's Hall Nursing Home. Staff told us they wanted to spend time with people and liked the people they supported. had time to spend with people and enjoyed being with them. We were told, "I do care, I couldn't do this if I didn't." Another staff member said, "I worry about residents if they're poorly." This demonstrated some staff were caring.

During the second, third and fourth day of the inspection we carried out observations when we saw staff being caring. We saw one staff member helping a person to walk. They had their arm lightly around the person's shoulders and were offering gentle encouragement. We observed one person being comforted by staff. We noted the staff member held their hand and gave them a hug. We also witnessed a staff member asking a person if they were comfortable in their bed. They tucked the person in and were speaking softly and kindly to them.

Care records we viewed were written in a respectful way and contained some person-centred information about people's social histories and backgrounds. Staff we spoke with could explain what was important to people who lived at the home, for example if they had family members who were important to them. We saw one person's care record had their preferred name recorded. During the inspection we saw staff used the persons chosen name.

People told us their privacy and dignity were respected and we saw this on inspection. We saw if people were hoisted to mobilise, blankets were used to ensure their dignity was upheld. We saw numerous

examples of staff knocking on doors and waiting for an answer before entering. While we were having a private conversation with a person in their room a staff member knocked on the door. We noted they waited for permission to enter. They apologised to the person for disturbing them and offered to come back and later as we were present. The person told them they had agreed for them to come in and not to apologise. They said to us, "That wasn't for your benefit you know. They do knock and wait."

We viewed a care record which informed staff privacy was important to a person who lived at the home The record informed staff of the steps staff were to take to assure this. We spoke with the person who told us staff maintained their privacy. This demonstrated staff were aware of the importance of supporting people to have privacy.

We spoke with the interim manager about access to advocacy services should people require their guidance and support. The registered manager told us they would ensure details were made available to people if this was required. This ensured people's interests would be represented and they could access appropriate support outside of St Wilfrid's Hall Nursing Home.

Staff we spoke with told us they had not yet received training in equality and diversity (apart from at induction) but they understood this was being sourced. This was confirmed by speaking with the regional trainer. They told us staff received training in this area on induction, but further training was being arranged. Staff we spoke with told us they would report any concerns they had if they believed people's human rights were not being upheld. Staff told us they valued each person as an individual and would report any concerns of discrimination to the interim manager, the local safeguarding body or the CQC so people's rights could be upheld. One staff member said, "We treat people as individuals with individual rights. I'm not afraid to report anything."

Requires Improvement

Is the service responsive?

Our findings

During this inspection we found care planning did not support the delivery of responsive care.

We noted two people lived with behaviours which may challenge. We looked at the care records for each person and saw no care plan or management plan was documented to support them. For example, we saw one person was given biscuits. Staff told us this helped to distract the person. We looked at their care record and saw they lived with a health condition which indicated they should not eat a lot of sugar. We showed this to the peripatetic manager who acknowledged the care record required more person-centred information to ensure the person was supported to manage their behaviours.

We also saw a staff member administered medicines to the person by a syringe and the person accepted this. A further staff member suggested a spoon or a pot could be used. The method of delivery was changed and the person refused their medicines.

We saw a person at the home was displaying behaviours which may challenge We looked at the second person's care records. Staff told us they spoke with the person to distract them. We viewed the person's care record and saw there was no management plan or care plan in the person's file to inform staff how they should support the person to manage their behaviours.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider had not carried out collaboratively an assessment of the needs and preferences of the person and designed care and treatment to achieve the person's preferences.

Prior to the inspection we received information of concern that people were not supported to bathe or shower and people did not have any toiletries. People we spoke with told us they were supported with personal care at a time they chose. We saw people had individual toiletries in their bedrooms. Staff we spoke with told us they supported people with personal care and would report any concerns to the interim manager. We looked at documentation to confirm this. We saw entries which read 'personal care'. Staff confirmed this could mean a bath, shower or wash was provided. We discussed this with the interim manager. They told us they would address this.

We saw people were given the opportunity to discuss their end of life care. One person told us they had been asked if they any information they wanted to share, but they had declined. Staff told us they were able to support people with end of life care and would seek guidance and support from external health professionals if this was required. Where appropriate care records documented the decisions people had made regarding their future wishes.

There was an activity programme on display and two activities co-ordinator's were employed to support the delivery of meaningful activities. During the inspection we saw people were asked if they wanted to take part in a sing song. We saw if people chose to attend they were supported to do so, if people declined their wishes were respected. We also saw there was an activity of a quiz taking place. We saw people were

supported to attend this if they wished to do so. Our observations showed people were smiling and enjoying the activity. We observed people clapping in time to music and talking together. This demonstrated people were supported to take part in activities which were meaningful to them to minimise the risk of social isolation.

We checked to see if people and their relatives were involved in care planning. Two people we spoke with told us they were. Of the relatives, one relative told us they were but they felt this was led by them. Two further relatives told us they were involved in discussions about care. Records we viewed were not always signed by people who used the service, or their relatives. We passed this to the interim manager for their consideration.

Care records identified any communication needs and staff told us they would support people if they needed to access information in a different way. For example, by using pictures or large print to support understanding. This demonstrated the registered provider considered people's individual needs.

St Wilfrid's Hall Nursing Home had a complaints procedure which was available to people who lived at the home. We reviewed the complaints procedure and saw it contained information on how a complaint could be made and the timescale for responses. One person told us they had made a complaint to the service and this had been resolved. People told us they would raise complaints with staff or the registered manager if they felt the need to do so. Relatives we spoke with told us they had not made any complaints to the interim manager or registered provider.

Staff we spoke with told us they supported people to make complaints. They explained people's rights to complain were respected and any complaints would be passed to the interim manager or registered provider to enable any investigations to take place.

We reviewed a complaint and saw this had been investigated and was in the process of being concluded. This demonstrated the registered provider had a complaints process which was used to investigate any concerns raised.

Requires Improvement

Is the service well-led?

Our findings

We saw audits completed by the senior management team which identified where improvements were required. Timescales were set for completion of resulting actions and the operations director told us they were committed to improving the service. The audits we saw had not identified all the areas of concern we had identified on inspection. For example, it had not identified the fire exit had a coded lock on it and not all staff knew the code to open it. We also found a person's mattress was set incorrectly and this had not been identified through checks on the equipment. In addition, it had not identified that people were being unlawfully deprived of their liberty. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as audits had not always identified the improvements required.

We discussed our concerns with the interim manager. They told us a full health and safety audit was planned to be carried out but before this they would arrange for the key pad on the door to be reviewed. They also said they would ensure the mattress was set on the correct setting for the person and all other mattresses would be checked. Prior to the inspection concluding we saw the mattress setting had been correctly amended. We were also informed an audit of all DoLS applications and restrictive practices would be carried out. The interim manager wrote to us and told us this had been completed and they had started to submit DoLS applications to the Lancashire Local Authority to ensure people were lawfully deprived of their liberty.

There was no registered manager employed at St Wilfrid's Hall 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.

Relatives we spoke with gave us conflicting views on the management of St Wilfrid's Hall Nursing Home. One relative told us they considered the home was well managed and one did not comment on the management arrangements. Four told us they felt improvements were required as the home was often busy and did not appear well organised. We asked staff their views on the management of the home. Staff told us they wanted a permanent manager to work at St Wilfrid's Hall Nursing Home. They told us they considered the interim manager was making improvements but they wanted continuity of management. Staff told us they had met with the interim manager and they were aware they could contact them for advice or to discuss concerns.

We discussed the registered manager vacancy and the feedback from staff and relatives. We were informed by the interim manager and the operational director that a permanent manager had been appointed. They explained they would be starting to work at the home when safe recruitment checks had been carried out and it was intended they would be applying to the CQC to become the registered manager. They told us they were committed to finding the right person so the home would have stable leadership. The interim manager told us they had been at St Wilfrid's Hall Nursing Home for eight weeks to ensure leadership was available for staff.

During the inspection we saw the home was not always well organised. Over the four days of the inspection we saw the nurses office was often disorganised with paperwork over surfaces. We received feedback from visiting health professionals who told us information was not always readily available when they requested it as staff could not always find what they were looking for. When we asked for information, staff and management were happy to help but there was sometimes difficulty in locating the information we requested. For example, we asked to see handover sheets. The qualified nurse looked for these and could not find them. They apologised and said, "It's always a mess in here. You can never find anything." We discussed this with the interim manager who told us they would address this as a matter of priority.

We looked at the arrangements for leadership. Staff told us a handover meeting was attended by the qualified nurse and the team leader. Staff were then allocated to separate floors and were given allocation sheets with their responsibilities on. In addition, a two-week rota had been introduced to help support stability and appropriate skill mix in the staff team. One staff member showed us their allocation sheet. They said it gave them direction and information. Staff confirmed they were deployed to specific areas of the home and were hopeful the interim manager would make improvements.
Staff we spoke with were able to explain their roles and responsibilities. Eight staff spoke positively of the support they received. They told us they could approach the interim manager or the senior staff to discuss any concerns or seek clarity on anything. Two staff told us they felt morale was low due to the changes in manager over the previous months. They told us they would approach the interim manager if there was a need to do so.

The interim manager told us they reviewed accidents and incidents to see if there were any lessons learned. They also told us the senior management analysed the accidents and incidents which occurred at the home to see if there were any trends. We were informed there were not.

Staff told us staff meetings took place and these were a way of receiving information and learning about changes that occurred at the home. We viewed the minutes of the most recent staff meeting and saw this contained information of the changes taking place at the home. For example, we saw staff had been reminded of the importance of completing documentation accurately and of the management arrangements at the home. This showed the registered provider informed staff of changes and of improvements required.

The registered provider sought to gain people's views and relatives and people we spoke with told us they could speak with the interim manager if they wished to do so. We saw a survey had been completed by some people who lived at the home. The survey concentrated on the meal provision at St Wilfrid's Hall Nursing Home. The interim manager told us this was currently being analysed to identify if changes could be made to improve the meal provision. We saw also saw a meeting had taken place with relatives. One of the areas identified for improvement was the laundry provision. Feedback had been received about people's clothes not being returned to them or being worn by another people. The minutes showed the interim manager was exploring the cost of labels as a way of addressing this. This showed the registered provider acted on comments and suggestions made by people who lived at St Wilfrid's Hall Nursing Home.

The operations director and the interim manager told us they were committed to making improvements and employing an appropriately qualified and competent manager. They explained they wanted people who lived at the home to have good care and they would continue to make changes and allocate resources until this was achieved. This demonstrated the registered provider was committed to improving the experiences of people who lived at St Wilfrid's Hall Nursing Home.

The home had on display in the reception area of the home their last CQC rating, where people who visited

the home could see it. This is a legal requirement from 01 April 2015.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not carried out collaboratively an assessment of the needs and preferences of the person and designed care and treatment to achieve the person's preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not consistently protected from behaviour which was degrading and peoples needs were sometimes disregarded. Regulation 13 (1) (4) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits had not always identified the improvements required. Records were not always contemporaneous, or an accurate reflection of the care given, or the support people required. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always safely recruited. Regulation 19 (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements did not allow people's needs to be answered promptly. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Equipment was not always used in a safe way. Medicines were not always managed safely. Care and treatment was not always provided in a safe way. Regulation 12 (1) (2) (e)

The enforcement action we took:

We served a warning notice for this breach in regulation.