Rotherwood Healthcare (Lynhales Hall) Limited

Lynhales Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 14 February 2017, with a further announced visit on the 17 February 2017.

Lynhales Hall Nursing Home is registered to provide nursing care and accommodation for a maximum of 73 older people. At the time of our inspection there were 57 people living at the home. Lynhales Hall Nursing Home is divided into two units. The 'main house' provides accommodation for up to 53 people. The 'John Sperry Unit' is a modern ground floor extension to the main building, which provides nursing care for up to 20 people living with dementia.

We last inspected this service in July 2016, however due to concerns raised about the quality of nursing care provided at the home this inspection was brought forward. During this inspection we identified four breaches of Regulations under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not protected people against the risks associated with the safe management of medication. Prescribed creams were not always given as prescribed by the GP. One person who had been prescribed a daily emollient for their skin condition, had not been applied for a period of nine mornings. People who were prescribed medicines to be taken 'when required,' such as for pain relief, information was not always recorded to help staff decide when the medicines were needed. Medicines were not always administered in accordance with the manufacturers' directions. One medicine was still applied after it should have been discarded. One person was prescribed a medicine to be administered twice daily. We found it was being given only once daily. Records supporting and evidencing the safe administration of medicines were not always complete and accurate. The provider did not always effectively monitor pain relief for people.

The management of Deprivation of Liberty Safeguards (DoLS) renewal applications did not reflect the requirements of the MCA. People were therefore being unlawfully deprived of their liberty without independent scrutiny. A number of DoLS authorisations had expired and that there had been delays in submitting reassessment applications, some of which were significant delays.

People were not always treated with respect and dignity. One person with a skin condition on their legs received treatment from a nurse in the main communal lounge, in the presence of other people, which placed the person in an undignified situation. They failed to ensure the privacy of the person when delivering care and treatment with little regard to their dignity.

The provider had failed to ensure that records were accurate, complete and contemporaneous in respect of each person.

The home lacked any clear strategy in relation to the effective monitoring of the quality of services provided by staff. Though the provider had management systems in place to record and monitor the standards of

care delivered within the home, these were not always completed or were effective. Medication management checks had been undertaken, but these failed to identify the series of concerns we found during our inspection regarding the safe management of medicines.

The provider had failed to display conspicuously and legibly their performance rating from there last inspection visit in July 2016.

There was no effective leadership. Staff told us that the registered manager had failed to provide support and leadership since their appointment. The registered manager told us they had resigned from the service as they had received no support from the provider. No improvement plans had been initiated following internal inspections undertaken by the provider.

Staff told us they were concerned about night time staffing levels at the home. However, during our inspection visit we were told that staffing levels had improved and we saw there was enough staff on duty to meet people's needs.

Supervision and support was inconsistent. We were therefore not confident that all staff received the support and development they required to undertake their role effectively.

We saw examples of both spontaneous and affectionate interaction and of less positive interaction between staff and people.

People and relatives felt that they or they family members were safe living at Lynhales Hall Nursing Home.

Staff had received training in how to recognise when people were at risk of abuse. Staff had received appropriate checks prior to starting work at the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The registered provider had not protected people against the risk of associated with the safe administration and management of medication.

People's risks were assessed and action taken to minimise risks to them.

Staff raised concerns about night time staffing levels throughout the home.

The provider carried out appropriate checks when recruiting new staff.

Is the service effective?

Requires Improvement

The service was not always effective

Some people had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority in place.

Regular staff supervision and support was inconsistent.

People received effective support to access a variety of health professionals to meet their specific health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider failed to ensure the privacy and dignity of people at all times.

We saw examples of both spontaneous and affectionate interaction and of less positive interaction between staff and people.

Staff understood the importance of supporting people to make day-to-day decisions and encourage people to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always accurately record information relating to people's treatment need.

People's spiritual needs were catered for.

There were systems in place to routinely listen to people's experience, concerns and complaints

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no effective leadership.

The provider failed to effectively assess, monitor and improve the quality and safety of services provided and maintain accurate, complete contemporaneous records in respect of each person.

The provider had failed to display conspicuously and legibly their performance rating from there last inspection visit in July 2016.

The registered manager had resigned from the service as they had received no support from the provider.

Lynhales 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection carried out on the 14 February 2017, with a further announced visit on the 17 February 2017. The inspection was carried out by two inspectors, a specialist advisor in nursing and an expert by experience. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection. The specialist advisor was a nurse with experience in general nursing, residential settings and dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authorities and Healthwatch for any information they had, which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. We received information highlighting concerns regarding the quality of care delivered at the home. We used this information to help us plan our inspection.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with the 13 people who used the service and four visiting relatives. Many of the people we spoke with were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between staff and people who used the service. Some people were unable to speak to us, so we used the Short Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received.

We reviewed a range of records about people's care and how the home was managed. These included 10

care records, 20 medicine administration record (MAR) sheets, five staff files, quality assurance audits and minutes from resident and staff meetings.

As part of the inspection, we spoke with the registered manager, the regional manager, the deputy manager, clinical lead, four nurses, eight members of care staff, two activities coordinators and the house keeper.

Requires Improvement

Is the service safe?

Our findings

At our last inspection visit in July 2016, we found medicine administration and management did not consistently ensure people's medicines were available and administered as prescribed. During this inspection, we found continuing concerns that medicines were not administered safely by the provider.

We spoke with staff and looked at records relating to the application of prescribed creams. We saw one person who was sat in the main lounge persistently scratching their left leg causing it to bleed. We found this person had been prescribed an emollient for their skin condition, which had not been applied for a period of nine mornings. The nurse was unable to tell us why the emollient had not been applied. Information recorded to guide staff on how to apply creams were incomplete and there was no information recorded to guide staff as to where to apply creams. Records confirming that creams had been administered were inconsistent and in certain examples did not exist. Though staff told us creams were administered as prescribed, this was not always demonstrated from the records we looked at.

We found the provider did not always effectively monitor pain relief for people. We saw one person who had sustained a fracture, had been discharged from hospital in January 2017 with instructions that 'Paracetamol 1g was to be given four times daily – increased dose to be continued'. We found that from the 2 February 2017, this person had only received 500mg as opposed to 1g, which was given four times a day. This meant the person had not received the pain relief that they had been prescribed. We spoke to this person who told us that they were experiencing pain. We spoke with the clinical lead, who was unable to explain this change in dose. The provider had failed to identify that the person was on a reduced dose of paracetamol and therefore their pain was not controlled as effectively as it could be. We found a number of people were prescribed medicines to be taken 'when required,' such as for pain relief. Information was not always recorded to help staff decide when these medicines were needed. We spoke to a permanent nurse who was able to explain when these medicines were required. However, with a reliance on agency nurses there was no information available to support them decided when these medicines were required, especially if people had difficulty communicating.

Medicines were not always administered in accordance with the manufacturers' directions. We found one medicine, where manufacturers' instructions clearly stated that the medicine should be 'discarded 28 days after opening.' The medicine had been labelled as opened on the 12 January 2017, but records indicated that the medicine had still been given on the 13 February 2017, when it should have been discarded on the 9 February 2017. We found another unopened bottle of this medicine dated 28 January 2017, which had been available for use at this time.

People were not always given their medicine in line with their prescription. For example, one person was prescribed a medicine to be administered twice daily. We found it was being given only once daily. Records supporting and evidencing the safe administration of medicines were not always complete and accurate. One person was prescribed a medicine to be taken three times daily. The full course of treatment was completed a day late, with no explanation recorded why the dose had been missed on one day. We also found a number of signature omissions in the records we looked at, which meant the provider could not

demonstrate that medicines had been administered correctly.

Medicines that should have been returned to the pharmacist in a timely manner had not always been undertaken. For example, flu vaccines had not been returned for disposal. The clinical lead told us that they had not yet had time to return them.

People did not always receive food supplements in accordance with their prescription. We found examples were people did not receive their food supplements, because the provider had run out of stock. For example, one supplement was prescribed four times daily was last administered on the 10 February 2017 and was still not available on day of our inspection 14 February 2017.

The provider had not undertaken medicines competency assessments of all staff that administered medications, to ensure safe practice. Though we saw some evidence of medicines audits, the registered manager and provider had failed to ensure effective systems were in place for the effective monitoring and checking of medicine administration.

The registered provider had not protected people against the risk of associated with the safe administration and management of medication. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

People that we were able to speak with and relatives told us that they or they family members were safe living at Lynhales Hall Nursing Home. One person told us, "Yes, I feel safe here, they look after us all very well." Another person said, "I do like it here, I should think everybody does. I'm in this big room, I like this room, they're very good staff. They're very pleasant, very friendly and they keep an eye on you, they watch over you." A visiting relative told us, "Very safe. My relative has had trouble with their chest, but I think they pick things up in places like this."

The provider had assessed, recorded and kept under review the risks associated with people's individual care and support needs. Staff told us about people's needs and how they managed risk, which included actions they would take to reduce or minimise the risks such as in relation to skin integrity, falls and nutrition. When people were involved in any accidents or incidents, staff explained to us the need to ensure incidents were recorded accurately and reported to senior staff or management team.

Care staff and nurses told us that day time staffing levels were adequate to meet people's needs. One member of staff told us that as resident numbers were down, staffing levels were ok as a result. However, should numbers increase, staffing levels would need to be reviewed. The regional manager told us that there had been a reliance on agency staff for both nursing and care staff up until December 2016 as a result of recruiting difficulties. Since then, the use of agency care staff had significantly reduced through new recruitment, though there still remained a reliance on agency nursing staff. On the day of our inspection, we found there were enough staff on duty to meet the needs of people.

We spoke to night staff about staffing levels at the home. Staff told us they were concerned about night time staffing levels at the home. We were told that on the John Sperry Dementia Unit, there were two care staff and one nurse on nights to meet the needs of 18 people at the time of our visit. One member of staff said, "Most people are double ups (needing two staff to support people), so if we are dealing with one resident, no one is available to watch wandering residents, unless the nurse can do it. We can't ensure people are safe, because they wander and some may fall." Another member of staff said "We have an agency nurse at nights all the time and some are not as good as others. They rely on care staff a lot, which frightens me." A third member of staff told us, "Three care staff is not enough (at nights). We have already made a request to the

regional manager. We need two staff to reposition people during the night as most residents are high dependency and at risk of pressure sores. We also have to keep an eye on people wandering around who are at risk of falls. The home does try to replace staff that are sick." We spoke to the registered manager about the concerns raised around night time staffing levels, who told us that staffing would be reviewed.

As part of our inspection we checked to see how people who lived at the home were protected against abuse. Safeguarding procedures are designed to protect vulnerable adults from abuse and the risk of abuse. Staff told us they had received training in how to recognise when people were at risk of abuse. Staff were able to describe what action they would take if they had any concerns and were aware of the service's whistleblowing procedures. Staff told us they would refer any concerns to the registered manager or senior staff and also check the local authority guidelines. One member of staff said, "We have whistleblowing policy in place and I have raised several concerns, which the home manager has acted upon. They have been referred to safeguarding and investigated."

Staff had received appropriate checks prior to starting work with people. They told us they did not start work until the provider had checked their identity, previous employment history, and obtained work and character references about them. A background check called a Disclosure and Barring Service (DBS) check was completed prior to staff commencing work. A DBS check is a legal requirement and is a criminal records check on a potential employee's background. These checks help to ensure that new staff were suitable and safe to work with people.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw best interest decisions had been made on behalf of people, which included relatives and health and social care professionals.

At this inspection we found that a number of DoLS authorisations had expired and that there had been delays in submitting reassessment applications, some of which were significant delays. We spoke with the newly appointed deputy manager who had undertaken a review of DoLS authorisation. They told us that they were currently submitting reassessment applications for people, where DoLS application had been previously authorised. We spoke to the clinical lead about these omissions, who told us that DoLS (reassessment applications) have been "overlooked," as they had other priorities such as addressing people's care plan needs.

In one example we looked at a DoLS authorisation had expired 2 March 2016, with a new application not submitted until 1 February 2017. A further example showed that another authorisation had expired on the 23 August 2016, with a new application submitted on the 1 February 2017. In total we looked at nine examples in the John Sperry Unit, where DoLS authorisation had expired without new applications being submitted until the 1 February 2017. There were a further 13 examples in the main house, where DoLS authorisation had expired and had not been renewed in a timely manner. The management of DoLS renewal applications did not reflect the requirements of the MCA. People were therefore being unlawfully deprived of their liberty without independent scrutiny.

Staff lacked understanding of the purpose of the MCA and what this meant for their work for people who were subject of a DoLS authorisation. Staff confirmed they had had training, however most were unable to explain the principles of the legislation and assumed everyone at the home was subject of a DoLS to prevent them leaving. One member of staff who had worked at the home for five months confirmed they had no understanding or training in the MCA.

This was breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to safeguarding people from abuse. A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

We saw people were asked for their consent and permission prior to staff assisting them with personal care or other tasks.

People told us they were supported by staff who were trained and able to meet their needs. New staff told us they all attended a period of induction, structured around their previous experience, before working on their own at the home. Staff with no previous experience of working in care were also required to complete and meet the required standards of the care certificate, before working independently. The Care Certificate is a nationally recognised training programme for care staff. When we spoke to the registered manager, they told us that though new staff completed the care certificate programme, to date 80 percent had still not been signed off as competent. One member of staff told us, "My induction consisted of two days training, which included manual handling. I was shown around and completed the care certificate with other on-line training. I 'shadowed' (working alongside more experienced staff) for a couple of days. The induction programme was ok for me. I felt I was confident and experienced." Another member of staff said "The induction was just ok, but it wasn't perfect. I'm still learning the needs of people who live here."

Staff confirmed they received regular training in subject such as dementia care and dealing with behaviour that was challenging. One member of staff us told that they thought training was ok, which had recently included physical intervention. They also said they felt the provider was very supportive when it came to training requirements.

We looked at how the provider ensured staff received regular supervision and support. The registered manager told us that supervision and annual appraisals of staff had been inconsistent and not in line with the provider's policy. They said it was because they had not received appropriate support from the provider to be able to manage this effectively. One member of staff told us they had not received any supervision since the current registered manager had been in post. They felt they had not been provided with any support from the registered manager. Another member of staff told us that they had occasional supervision from the team leader or nurse, but this was not regular. A third member of staff felt they had been given the appropriate support from management and received supervision.

We looked at how people were supported to maintain good nutrition and hydration. One person told us, "The food is good and bad, not much choice." Another person said, "We always have a nice lunch. There's not much choice and I eat what I'm given. I'm not fussy." One relative told us, the food was adequate and plentiful. They said their relative ate well and that the home did the best they could. They also told us that their relative used to be on a pureed diet until it was changed to a soft diet following a referral to the Speech and Language Team (SALT). As a result, their relative no longer needed a special plate and that they could now feed themselves. Another visitor said, "The food wasn't very good, but it really has improved now. They leave my relative to their own devices and they can take about 90 minutes to eat their food. They have loads to drink."

We observed lunch in both units of the home. In the main house dining room, we saw a noticeboard displaying the menu for the week, with a list of people needing supplements in their drinks. Information was also available to staff of people who were on special diets, such as soft or diabetic diets. Aprons were available and used by both people and staff. Meals were served from a heated trolley brought into the room from the kitchen. People in both units were given a choice of drinks and supported with their meals if they needed assistance. Staff encouraged people to eat and drink throughout the lunch period. In the John Sperry Unit, people were served from a kitchen area adjacent to the dining area. People were asked by staff what they wanted to eat and whether they wanted anything different. We asked staff in the main house if alternative choices were available if people didn't like their meal. We were told that people could have something else if they asked for it the previous day or early on the day in question, "to give us time to

prepare." There was a choice of desserts available. Some people were provided with finger food to meet their needs.

We found people received effective support to access a variety of health professionals. These included GPs, optician, diabetic nurses and speech and language therapists. One relative told us, "Liaison with outside agencies is very good." They confirmed that the GP, dentist, and chiropodist visited the home regularly.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with respect and dignity. We saw one person who was sitting in the main lounge was persistently scratching their leg. The person's leg was very dry, which they scratched repeatedly. Flakes of dry skin were displaced on to the floor. The skin on the person's legs was inflamed and scaly and started to bleed. We informed a member of care staff who went and found a nurse. The nurse then began to treat the person's leg by wiping clean the blood in the main communal lounge, in the presence of other people, which placed the person in an undignified situation. They failed to ensure the privacy of the person when delivering care and treatment with little regard to their dignity.

During lunch, we saw one person's cardigan had slipped from their shoulder, which was bare. The cardigan looked too big for the person and they said they were cold. There were a number of staff present in the room at the time, either serving the meals or supporting other people. Though staff approached the person to check that they were managing to eat their meal, they failed to adjust the person's cardigan and cover up their bare shoulder. Staff did not adjust this person's clothing until towards the end of lunch service, 20 minutes after we had first noticed the issue.

We saw another member of staff putting stockings on a female resident in lounge area, whilst other people, both male and female were present. We then saw the member of staff take the person to the bathroom without explaining to the person what they were doing.

We saw examples of both spontaneous and affectionate interaction and of less positive interaction between staff and people. However, we saw a member of staff being abrupt to a person and said "Turn around and get closer to the chair," when supporting a person with a beaker of tea. The person who was standing up was given a biscuit, which they immediately dropped on to the floor. The biscuit was picked up by another member of staff. We saw a member of staff trying to give a ball to a person in an effort to encourage the person to play with the ball, which kept falling to the floor. This amused both the staff member and another member of staff with no apparent regard for the person. We saw the same member of staff randomly approach people to encourage them to play with the ball, but with little or no interaction.

We observed one person helping a member of staff to decorate the John Sperry Unit with paper hearts and balloons for Valentine's Day. The member of staff was kind and compassionate and they laughed together about St. Valentine's Day. We saw another member of staff in the same unit sitting and holding the hands of a person, providing reassurance and kindness. We saw a further member of staff gently stroke a person's face to rouse them to tell them they had brought them a cup of tea. We saw a member of staff read a poem to a person, who was clearly pleased with this. The staff member told us that the person sometimes became agitated, but they had been an artist and enjoyed poems. When a person became anxious we saw that staff were quick to respond by taking the person for a little walk around the room and looked out of the window together at the birds and animals.

People told us staff were kind and caring. One relative told us, "The staff are very good, but we've lost some. There's a lot of agency staff and they don't know the clients." Another relative said, "We're very happy, the

care that (person's name) gets is wonderful. They do their level best. On the whole our relative has the same carer. It's marvellous for or relative" Some people us told they were actively involved in their relative's care, while others said they had not been consulted. One relative told us, "I'm very involved in my relative's care, I'm consulted and informed."

We asked staff how they promoted people's independence and choice. Staff told us they understood the importance of supporting people to make day-to-day decisions, which included what they wanted to eat or wear. One member of staff told us, "When assisting with feeding, we will give people cutlery and just guide them as they eat. We encourage people to do things themselves. We have one person who loves hoovering, so we support them doing this." We saw staff encouraging people to eat or mobilise independently. A visitor told us a hairdresser visited the home and that their relative enjoyed the service.

Requires Improvement

Is the service responsive?

Our findings

We spoke with one person who told us they had been feeling unwell for some time and that they had a bad cough. They told us that staff were not concerned. We spoke with a member of staff who was aware of the person's current condition and cough. We looked at this person's care file, which stated the person had a history of pneumonia and reoccurring chest infections. Information in the care file indicated the person had not seen a GP since November 2016 and nothing was recorded about the person currently feeling unwell.

We spoke to the clinical lead about the person. They told us that the person had been "alright yesterday." From looking at the care file it was not clear to us how the monitoring and recording of changes to person's health and wellbeing was being managed, especially as staff were aware of the person's cough. We were subsequently told that the clinical lead had arranged a GP's appointment for the person.

One person who spoke to us was very distressed and told us they had taken an overdose of paracetamol. When we spoke to the clinical lead about this incident, they told us that the person often displayed this behaviour. When we reviewed this person's care file there was no information recorded about this behaviour or what action staff were required to take in the event of such a disclosure. There was no information addressing the risk of self harm or any protocol around how staff were to treat reported claims and what support they should provide. We were subsequently informed by the provider that the care file had been updated and a referral made to mental health services.

One person told us they had sustained a fracture and that they required pain relief as a result. They told us they were in pain. When we looked at this person's care file, the only recorded information about the fracture was a care plan review on 8 January 2017, which stated, 'Fractured their tibia.' There was no information as to how it had been sustained or when. There was no information available for staff as to how pain relief should be managed. As we have said earlier in this report, we found the incorrect dose of pain relief was being administered by staff and that the person was experiencing pain. We spoke to the clinical lead who told us they would address the correct dosage issue immediately.

In one care file we looked at, the front sheet stated that the person was 'for resuscitation,' with 'Do Not Attempt Resuscitation' crossed out. On examination of the care file, we found a 'Do Not Attempt Cardiopulmonary Resuscitation form' dated 27 January 2017. This meant that the person was at risk of receiving care and treatment against their wishes. We spoke to a nurse who told us the person was 'not for resuscitation' and that they needed to amend the front sheet to ensure the person's preferences were respected and were correctly recorded.

We found care plans did not always accurately record information relating to people's treatment needs. One person who had a skin condition and diabetes, we found there was no supporting information available within the care file as to how both these conditions should be managed. We saw that this person had very dry skin, which was irritating and uncomfortable. It was unclear in the care file what the skin condition was, or how it should be monitored or treated. There was no current information recorded regarding how dry and sore the person's legs were.

We looked at the care file of one person who used protective head equipment. We found an occupational therapist had undertaken a review of the person's use of their equipment. This information was not recorded in the care plan. We spoke to the clinical lead as to where this information was located and was told we could find it on the back of the person's wheelchair, which we found to be correct. Personal confidential information should be maintained securely at all times.

This a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This was because the provider had failed to maintain accurate, complete contemporaneous records in respect of each person.

The home provided a specialised unit for people living with dementia. It was bright and airy and was purpose built for the care of people living with dementia. However, in the main house, there were a further number of people who were also living with dementia. We found corridors and passageways in the main house were not signed or differentiated by means of colour or themes to stop people becoming disorientated. There were no dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. We did not see any facilities such as 'rummage boxes, with tactile items or other items of general interest around the home for people living with dementia to pick up and investigate. We found the home did not have adequate signage features that would help to orientate people, such as memory boxes outside their room or bathrooms and dining areas clearly marked. We spoke to the registered manager who told us that the provider intended to address these concerns moving forward.

The provider had appointed activities coordinators throughout the home. We looked at an activities calendar, where a number of activities had been arranged, which included, art and craft, cookery, valentine's days activities and music and exercises. One visitor told us, that the home was trying to introduce more activities, but a lot of people just slept most of the day. They said that their relative was taken outside for a walk, but it was not a regular thing. During the inspection we saw staff engaging with people in activities, such as making decorations for the Valentine's day events, where a film and ice-cream afternoon had been was planned to which friends and family were invited. Staff told us that a local priest visited the home who was happy to talk to people of any denomination about their spiritual needs. One activities coordinator told us, "You can make a difference with activities, it brings out the best in residents. We're pretty much starting from scratch and there's quite a bit of stuff on order, such as various musical instruments and sports equipment."

We found the service had systems in place to routinely listen to people's experience, concerns and complaints. People told us that they had been provided with information on how to complain and would not hesitate concerns with staff or management. The service had a complaints policy and procedure in place. This provided information about how people could inform staff if they were unhappy about any aspects of the service they received.

Requires Improvement

Is the service well-led?

Our findings

When we last visited the home in July 2016, we found that management systems were not always effective. During this inspection, we found the home lacked any clear strategy in relation to the effective monitoring of the quality of services provided by staff. Though the provider had management systems in place to record and monitor the standards of care delivered within the home, these were not always completed or were effective. For example, though medication management checks had been undertaken, these had failed to identify the series of concerns we found during our inspection regarding the safe management of medicines. At this inspection we identified four breaches of regulations. The registered manager had not identified where improvements were needed and had not identified the concerns we had found. We spoke to the registered manager who told us that no infection control audits, bed rail or mattress checks had been undertaken. Staff supervision and development was inconsistent and only one staff medication competence check had been undertaken since July 2016. A number of DoLS authorisation had expired, which had not been identified through the provider's own system of checks.

We found there were no management system in place to ensure care files were accurate and complete and that people's needs were being effectively addressed. For example, a number of care files we looked at failed to address people's health and well-being needs. The registered manager acknowledged these concerns and told us they recognised the priority of ensuring that all care files were reviewed and updated. There had been a lack of progress in improving the service since our last inspection.

Some staff told us they were not supported in their role by management. One member of staff told us they felt there was no consistency or guidance about their role.

This a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This was because the provider had failed to effectively assess, monitor and improve the quality and safety of services provided.

During our inspection visit, we found that the provider had failed to display conspicuously and legibly their performance rating from there last inspection visit in July 2016. This is a breach under Regulation 20A Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). We spoke to the deputy manager, who took immediate action to ensure the notice of assessment was displayed in the main hallway, before our departure and we subsequently confirmed rating were displayed on the provider's web-site.

We found leadership at the home was ineffective. The current manager had registered with CQC in September 2016, though had been in post during our last inspection in July 2016. Some staff told us that morale was low and they did not feel listened to, or supported and appreciated by the registered manager. One member of senior staff told us that the registered manager had failed to provide support and leadership since their appointment. They stated that the registered manager had failed to allow nursing staff to review and update care plans. They claimed that communication within the home was poor, because weekly meetings that had taken place had been stopped since the appointment of the registered manager. These meetings were described as a key opportunity to find out what was happening in the home. This member of

staff claimed that good nursing and care staff had left the service, because of the blame culture that had developed. They also told us that the regional manager was providing a lot of support and that they wanted make improvements in the running of the home.

When we spoke to the regional manager about these concerns, they told us that the registered manager was relocating to another area. They acknowledged the relationship between staff and the registered manager had been difficult, but they now believed the home had turned a corner. They told us that staffing levels had stabilised, a new deputy manager had been appointed and that they would be advertising for a new registered manager shortly.

We spoke to the registered manager about the concerns we had identified during the inspection and about the support that they had. They had told us during the inspection that they had resigned from the service and their last day was effectively the 17 February 2017, the second day of our visit. They told us that the reason for their resignation was that they had received no support from the provider in a number of key areas including staffing and care files. They stated things had not improved since the appointment of the regional manager and no support had been given by the new operations manager. They stated that no improvement plans had been initiated following internal inspections undertaken by the provider. As a result, they felt they could no longer work for the provider.

One relative told us, "Visitors are always welcome. Contact with the home is very good but there's not always a nurse in the reception area and I don't always know who's in charge. The staff are very good, but we've lost some. There's a lot of agency staff and they don't know the clients." Another visitor told us about their concerns about the manager and the management of the home. They told us they had met with one of the Directors to discuss these issues and felt more optimistic that things would get better. This person told us they had not see enough of the registered manager on the floor and that the new deputy manager was 'hands on.'

Most staff told us they felt supported and listened to by senior staff and management, they had a good team spirit and everyone was good at supporting each other. We were told the home needed permanent staff and management. One member of staff told us that when they had raised issues with management, which included concerns about staffing levels and training, but these issues had not been addressed.

The provider had when appropriate submitted notifications to the Care Quality Commission. The Provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This enabled us to be able to monitor any trends or concerns.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risk of associated with the safe management of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of services provided and maintain accurate, complete contemporaneous records in respect of each person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display conspicuously and legibly their performance rating from there last inspection.