

Rosecare Homes Limited

Andrin House 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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 1 October 2018 and was unannounced. We returned announced on 2 October 2018.

Andrin House Nursing Home accommodates up to 37 people in an adapted building. At the time of the inspection 23 people were using the service. People using the service have an identified nursing need, which includes people living with dementia.

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

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At the last inspection on 23 and 24 April and 2 May 2018, we asked the provider to take action to make improvements. To promote the safety and welfare of people and further promote their safety and well-being through robust staff recruitment processes and the ongoing supervision and appraisal of staff. To provide care and treatment that was personalised and met their needs. To meet their conditions of registration through the appointment of a registered manager. And to have effective governance arrangements to monitor the quality of the service.

The provider had taken action to make improvements following the Care Quality Commission (CQC) inspection of April and May 2018.

Andrin House Nursing Home had a 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 provider had engaged the services of a consultancy firm to support them in bringing about the required changes to the governance of the service. The registered person reviewed internal audits as to the quality of the service that were carried out by the registered manager. However, audits in two areas, care planning and medicine, had not identified the shortfalls found through the CQC inspection. The registered person and registered manager, regularly met to review their progress in the changes made.

The registered person and registered manager, with the support of the consultancy firm were looking to

prioritise further plans for improvement, based on risk, detailing the improvement, how it was to be made, the person with the overall responsibility and the timescale involved.

The provider had been transparent and had displayed the rating following the previous inspection within the service and on the website as required by legislation. The provider had met with staff following the previous CQC inspection and the minutes noted they had taken responsibility for the shortfalls found and discussed the areas for improvement.

People using the service, family members and staff had completed questionnaires to identify areas of improvement. The registered manager had analysed the results and had made tangible improvements in the day to day management of the service, which had had a positive impact on people using the service and the staff employed.

The registered manager had reviewed the policies and procedures for the service and had undertaken a range of audits to assure themselves of the quality of the service being provided. A system for supporting staff had been introduced, which included regular supervision, meetings and training. Information kept within staff files had been reviewed by the registered manager and updated where appropriate. Staffing levels were kept under review and were flexible to meet the needs of people.

We found improvements were required to ensure information was consistently in place for staff to follow, where medicine had been prescribed to be taken as and when required, to ensure consistency of its use. We found improvements in the monitoring of the safe storage and administration of medication had been introduced. People were confident that they received their medicines as prescribed and records confirmed this.

We found improvements were needed to documentation completed by staff recording people's care and support. We found there was duplication of some information along with missing information. Not all records were stored in one place, which meant some records were not always being completed. This meant that when people's needs were reviewed some information was not being considered. The registered manager confirmed that documents to record people's specific needs, such as dietary intake would be reviewed. To support the effective use of information to help staff in the reviewing of people's care to ensure it met their needs.

Potential risks to people had been reassessed with the involvement of the person and family member. Measures had been introduced to reduce potential risks and these were documented with clear links to people's care plans. People using the service and family members were confident that they were safe.

People's capacity to make informed decisions had been considered and family members had been involved in the assessment process and the development of care plans. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed positive interactions between people using the service and staff. People's privacy and dignity was supported and staff were aware of the importance of confidentiality. People in the main spoke positively about staff and the service and care they received.

People's care, support and treatment had been reassessed and had been used to develop care plans reflective of people's needs, which were person centred reflecting their wishes and preferences and included the views of family members. People's care plans included, people's wishes regarding end of life care, where

they had chosen to share their views.

People using the service and family members were aware of recent changes in the management of the service. Family members, told us they appreciated the direct approach of the registered manager and confirmed that any comments they had made had been acted upon. Family members were aware of how to make a complaint, however they told us they had had no need to make a formal complaint.

The noticeboard provided information on a range of topics, which included the complaints procedure, the date of future events including social activities and dates of meetings for those using the service and family members.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Assessments had been undertaken to identify potential risks to people and measures put in place to promote people's safety and included the analysing of accidents and incidents.

People who were prescribed medicine to be taken as and when required did not consistently have guidance as to the frequency and circumstances for its safe administration.

Improvements had been made to promote people's safety through improved infection prevention and control measures, further improvements were identified and acknowledged by the registered manager.

Requires Improvement 

Is the service effective?

The service was not consistently effective.

Policies and procedures for the recruitment and ongoing supervision and monitoring of staff had been reviewed and implemented.

A policy specific to the assessment process to determine people's needs prior to admission into the service was not in place. People using the service had had their needs re-assessed.

People's dietary and hydration needs were met, improvements were needed to ensure accurate recording of people's food and fluid intake.

People's health care needs were monitored and referrals to external health care professionals were made in a timely manner.

Improvements to the environment were ongoing. Further developments to support people living with dementia could have a positive impact on their well-being.

Assessments to determine people's capacity to make informed decisions about their care and treatment had been undertaken.

Requires Improvement 

Is the service caring?

Good ●

The service was caring.

People and family members spoke positively of the care and support they received.

People confirmed that their privacy and dignity was respected and that they made day to day decisions about their care that were respected by staff.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People and family members had been involved in the development of new care plans, which enabled them to influence the care, treatment and support they received. And for some people, included information as to their wishes for end of life care.

Records detailing aspects of people's care, support and treatment were not consistently completed.

People and their family members were confident and knowledgeable about making a complaint. Concerns had been responded to by the registered manager.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

A registered manager was in post.

Audits were undertaken on a range of areas; however, audits had not consistently identified shortfalls found through the CQC inspection process.

The provider and the registered manager had identified further areas for improvement. A plan detailing how and when these were to be achieved was not in place.

The provider with the support of a consultancy firm and the registered manager had developed processes to audit the quality of the service. Plans to further develop effective governance through quality assurance were being considered.

People using the service, family members and staff views had

been sought and opportunities for further comment through meetings were in place.

Improvements had been identified by external stakeholders.

Andrin House 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.

We inspected Andrin House Nursing Home on the 1 October 2018 unannounced. We returned announced on 2 October 2018.

The inspection was carried out by two inspectors', a Specialist Advisor (the Specialist Advisor had experience working and caring for people who have nursing needs) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We spoke with three people who used the service. We spoke with three family members visiting their relative. A family member shared their views about the service by telephone. We spoke with the registered person, registered manager a nurse and two members of the care staff team.

We reviewed the care records of eight people who used the service. We looked at four staff records, to evidence their recruitment, induction, on-going monitoring and training. We looked at the minutes of staff meetings and people using the service and their family members. We examined documents which recorded how the provider monitored the quality of the service being provided.

Is the service safe?

Our findings

At our previous inspection of 23 and 24 April and 2 May 2018 we found the registered person had not ensured risks to the people using the service were mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had been made at this inspection.

Risk assessments, which were comprehensive had been undertaken following the Care Quality Commissions (CQC) inspection of April and May 2018. Risk assessments had identified potential risks and included information about measures to be put into place to reduce the risk. For example, a person who mobilised independently was found not to need bed rails as they were not at risk of falling from their bed. However, the assessment found the person was at risk of falls when initially getting out of bed. To reduce the potential risk, but to safeguard the person's independence a sensory mat was placed next to their bed to alert staff that they had gotten up. The care plan directed staff to respond promptly to the activation of the sensory mat, to promote the person's safety.

Risk assessments had considered people's mental capacity to make informed decisions. People's responses to questions asked about their care and support and understanding of potential risk were recorded. Where it had been determined the person did not have capacity to make an informed decision, a best interest decision was made and linked to the person's risk assessment and care plan. Family members had been involved in the assessment and care plan process, and family members views had been recorded on the mental capacity assessment.

Risk assessments promoting people's safety should an incidence occur, which may require the evacuation of the service had been reviewed and updated since the CQC inspection of April and May 2018. Each person had a Person Emergency Evacuation Plan (PEEP). The PEEP provided information as to the level of support a person may require, including the use of equipment such as a wheelchair should they need to leave the service in an emergency. The PEEP included the nearest evacuation point, based on their being in a communal area or in their bedroom.

Staff were seen to use appropriate moving and handling techniques and spoke to people, explaining what was happening and providing reassurance when using a hoist. People who mobilised independently with aids were patiently encouraged to rise from sitting to a standing position safely.

Since the CQC inspection of April and May 2018 the registered manager had introduced 'walkie talkies' into the service. Staff who provided people's personal care and support, were able to contact each other, discreetly, to request for assistance. This meant, staff did not have to leave a person unattended to request assistance. This had a positive impact on people's safety and effective use of staff resources.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they had

been assessed as safe at the time of their inspection.

We found some people were prescribed medicine to be given as and when required. Not everyone's records included guidance detailing the circumstances in which the medicine was to be administered. The registered manager informed us they would ensure guidance was put into place.

People expressed confidence in the management of their medicine. One person told us, "Medication is given to me regularly and they never forget to give it to me." A second person said, "I have medication regularly, they (staff) do not forget to give them to me." A third person said, "If I am in pain, the staff would support me if I tell them."

The registered manager had reviewed policies and procedures for medicines. The policies were linked to best practice guidance provided by National Institute for Health and Care Excellence. (NICE, provides national guidance and advice to improve health and social care). Our observations of medicine administration were positive. The nurse administered each person's medicine individually, in a calm and considered approach, the nurse explained to each person about their medicine and ensured the medicine had been taken before signing the medicine administration records (MARs).

Nurses or senior carers who had received training in the safe administration of medicine were responsible for the administration of people's medicine. Care staff did apply topical creams as and when required, for example following the delivery of personal care. We found (MARs) were signed when all medicines were administered. Medicine was stored appropriately, and the temperature of the storage facilities were checked and found to be within an acceptable range. Appropriate systems and facilities were available for the destroying and return of medicines which were not used.

People's mental capacity to determine their understanding of the importance of taking medicine and the impact of not taking their medicine had been assessed. Where it had been determined the person did not have capacity to make an informed decision, a best interest decision was made and linked to the person's care plan, which stated the responsibility to ensure the person took their medicine was the responsibility of staff. People's family members had been involved in the care plan process, and family members views had been recorded on the mental capacity assessment.

People's care plans for medicine, included information as to the medicine they were prescribed and any known allergies. The care plan included specific instructions around their medicine, for example one person's care plan stated one of their medicines was not to be given on a specific day each week. This was because another medicine they took once a week could not be taken together as the medicines interacted with each other. We found further positive examples, of the recording of specific instructions to ensure people's medicine was effective when administered. People's care plans stated how the person took their medicine, for example with water. Care plans included information as to how people who were unable to verbally communicate, expressed pain to enable staff to respond appropriately. The care plans were reviewed monthly and any changes recorded.

The registered manager had reviewed policies and procedures for infection control. We found the policy did not contain information for the formal checking of the condition of mattresses (a damaged or compromised mattress cover increases the potential for the spread of health care acquired infections). The registered manager informed us they would introduce a system to check the integrity of mattresses. An external contractor carried out periodic checks on mattresses and beds. Audits on infection control were undertaken by the registered manager and any shortfalls were identified.

We found improvements around infection control and prevention had been made. For example, new bins had been purchased for both infectious and household waste. All bins had a lid, to reduce the spread of infection. There were a number of locations throughout the service, which provided staff with easy access to personal protective equipment, to reduce the risk of the spread of infection, such as gloves and aprons. The registered manager had considered the action plan of January 2018 that had been provided following an infection control audit carried out by the Clinical Commissioning Group (CCG).

People and family members shared their views about the cleanliness of the service. One person told us, "The laundry is well done and very effective." A second person said, "It is always clean and tidy here." A family member said, "This room is clean but dated."

The registered person had met with staff following the CQC inspection of April and May 2018, at the meeting the registered person had spoken with staff about the improvements that would need to take place, which included improvements noted by other key stakeholders.

The registered manager assured us that each nurse as a requirement of their registration with the Nursing and Midwifery Council (NMC) was required to keep themselves apprised of good practice guidance. The registered manager had recently identified key areas, where a named member of staff was to take the lead. The four areas identified were, health and safety, end of life care, infection control and fire. The plan was for the staff leads to develop links with external organisations to share good practice and ideas amongst the staff team.

The registered manager informed us they received alerts by e-mail from external organisations, which informed them of safety alerts or recalls about equipment, including medicines. They told us they reviewed the information to determine whether any action was required, however there was no record of this. The registered manager responded positively to the idea of sharing alerts and good practice guidance within meetings held for nursing staff to embed and develop safety and good practice.

The registered manager reviewed all accident and incident reports, monthly. Any themes were identified. For example, the registered person had noted that one person using the service had a number of incident reports recording changes to their behaviour. The registered manager themselves identified that the person was displaying behaviour that challenges with greater frequency. The person had been referred to the relevant health care professional and their medicine had been reviewed.

A family member told us, "Whenever I visit [relative], I have never heard harsh words spoken to any of the residents by members of staff."

We found staff to be knowledgeable as to their role in promoting people's safety, which included their awareness of reporting concerns about potential abuse. Staff understood that it may be difficult to determine whether there was potential abuse if it was not witnessed. Staff were able to describe potential indicators that abuse may be occurring, for example unexplained bruising or changes in people's behaviour.

Staff were aware of the agencies they could contact should they have concerns, which included the local authority, police or the Care Quality Commission (CQC). The policy and procedure for safeguarding had recently been reviewed. We found it referred to the local authority however, it did not include their contact details. The registered manager said they would update the policy and ensure contact details for local organisations, including advocacy services were included and displayed.

People told us they felt safe at Andrin House Nursing Home and why. One person said, "I feel safe, because of the willingness of the staff to look after us." A second person said, "I feel safe as there is always someone about." A third person said, "They (staff) check up on me at night." Family members told us their relatives were safe and why. A family member said, "[Relative] was a falls risk, but they (staff) support her to be independent." A second family member told us, "There is always someone here to look after and support [relative]." A third family member said, "[Relative] had the guard up on the bed and staff take care of her."

One person when asked about staffing levels told us, "I don't think there is always enough staff." Family members shared their views about staffing levels. One family member told us, "Most of the time there is enough staff, not always." A second family member said, "Sometimes they seem like they are short staffed."

The registered manager kept under review the level of support people required. This information was then analysed to determine the staffing levels required to promote people's safety and provide safe care. We looked at the staff rota and found a nurse was on duty always. Each shift had a senior carer on duty, who was supported in most cases by three members of staff during the day. Two members of care staff were on duty during the night, who worked alongside a nurse.

We found there were sufficient staff to meet people's needs. On the first day of our inspection, an additional two members of care staff were on duty as they were supporting people to access health care and clinic appointments. We saw evidence, that additional staff had been rostered for future appointments. This showed people's individual needs were taken into consideration to ensure people received the care and support they required.

To support the safe and efficient running of the service staff were employed in other key roles, which included cleaning, laundry, maintenance and catering.

Is the service effective?

Our findings

At our previous inspection of 23 and 24 April and 2 May 2018 we found the registered person had not implemented a robust system for the recruitment of staff and their ongoing supervision and appraisal. We issued a requirement notice as this was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had been made at this inspection.

The registered manager had reviewed all staff files and had requested staff provide evidence of missing documentation, which had been identified at the CQC inspection of April and May 2018. This included information verifying people's identification and the completion of a health declaration. The recruitment policy and procedure had been reviewed by the registered manager, which reflected the legislation governing the safe recruitment of staff. The provider and registered manager had not recruited any staff since our previous inspection. The registered person and registered manager confirmed that the policy and procedure would be adopted, should new staff be recruited.

The policy and procedure for the supervision and appraisal of staff had been reviewed by the registered manager. Staff records showed that the supervision and appraisal policy had been implemented, with records showing staff had regular supervision and had had their work appraised. The policy stipulated that all staff were to receive a minimum of six supervisions each year, and for nursing staff these would include clinical supervision. There was flexibility, which showed additional supervision was provided where required. The supervision policy required the supervisor and supervisee to be prepared, with topics for discussion to be identified to ensure clear messages and themes were consistently discussed and recorded. Supervision notes had been made, with the supervisor and supervisee both having to sign stating the notes were an accurate reflection of the points discussed.

Staff told us they were regularly supervised and found them to be useful. One staff member said, "It helps us to improve, to find out the things we need to bring up our standards in. I now know I need to be better at writing up the notes of the care I give, because I was told at my supervision." A second staff member said, "I am starting to do supervisions now, they are helpful." They went on to say that the registered manager was responsible for staff appraisals.

We found there was no policy and procedure for the assessing of people's needs prior to their moving into Andrin House Nursing Home. People's reassessments had been carried out without the support of a policy. The registered manager stated the assessment process was incorporated into other policies and procedures. The lack of a policy, stating the procedural guidance relating to timescales and commitments relating to the assessment process, was therefore open to potential challenge. The Care Quality Commission (CQC) recommends a policy and procedure for the assessment of people's needs, to determine whether the service can meet their needs, prior to people's admission be developed and shared with partner agencies.

Assessments of people's needs, who were already in residence at Andrin House Nursing Home had been undertaken since the CQC's previous inspection of April and May 2018. The registered manager with the support of nursing and care staff had reviewed everyone's needs. All aspects of their care, treatment and

support had been reassessed, which included personal care, medicine, communication, nutrition and diet and referred to specific health care needs and medical conditions. Those using the service and their family members had been involved in the reassessment process and their views had been recorded. These assessments had been used to develop people's care plans.

The assessments of people in some instances had identified their food and fluid intake was to be monitored, with further information as to the person's specific needs detailed within a care plan. Whilst care plans for people's nutritional needs were comprehensive, supplementary records detailing the amount people had drank were not always completed. Information about people's fluid intake was discussed at staff handover, but not the specific action staff were to take. The registered manager confirmed they would instruct staff to provide greater written detail of staff handover.

Assessments had been undertaken on people's mouths as part of the assessment process. This required staff to assess for signs of dehydration, the general condition of people's mouths and whether the people had teeth or dentures. The registered manager had enlisted the service of a person who would visit people to undertake mouldings, should people require dentures.

People's views about meals were mixed. One person told us, "The food tastes like they are the cheapest cuts of meat and food is like they are working to a very tight budget." A second person said, "I think the cooks would benefit by going on a cooking course." A third person said, "We are given a choice of two meals." A family member said, "When I visit there are always drinks too hand for her to reach."

We observed staff offering drinks throughout the day and people showed no signs of dehydration. Dining tables displayed the menu for the day, we did note that table mats and aprons were in poor condition, being tattered and worn. A majority of people ate their lunch sitting at one of the dining tables and on both days, we observed people ate the majority of their meal. Those who required assistance with their meal were supported by staff. We saw staff describe to a person the food being offered, enquired as to the temperature of the food and whether they liked what they were being given. We saw staff gently stroke the person's hand to keep their attention and coaxed the person gently to eat, giving the person plenty of time to finish each mouthful.

During the day a member of catering team was seen supporting a person to make choices for their midday meal, they did this with patience and gently prompting them demonstrating they knew what their preferences were, by saying, "I know you like a bit of fish without sauce."

A person who received their nutrition via an alternative method, known as a PEG (percutaneous endoscopic gastrostomy) which meant their nutrition is passed via a tube directly in the stomach, had a comprehensive care plan in place. The person's care plan reflected NICE guidance. (National Institute for Health and Care Excellence), which provides national guidance and advice to improve health and social care) and included advice from a specialist dietician. The care plan provided clear guidance as to the safe maintenance of the PEG and records showed staff acted upon this. The person's care plan stated their weight was to be monitored weekly and identified the action to be taken should the person's weight fall below an identified level. We found a dietician had been contacted when the person had lost weight and the action recommended had been acted upon and the person was gaining weight.

One person commented as to the positive impact of having a consistent staff team. They told us, "The staff is consistent, so they know the residents. It's like family." Family members expressed confidence in the ability and knowledge of staff to meet their relative's needs. A family member told us, "At least 99% of the staff seem to know what they are doing when they are looking after [relative]."

Staff records provided evidence of the training undertaken by staff since the CQC inspection of April and May 2018, training topics were related to the promotion of people's safety, health and wellbeing. For example, topics included dementia care, safeguarding adults, medicines management, moving and handling people safely, health and safety, continence care and food hygiene.

Staff spoke positively about the training. One member of staff said, "I've done my training, I've just done moving and handling and first aid. I've done my Care Certificate, but not medicines yet, as I am not a senior carer. (The Care Certificate is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.)

A second member of staff said, "The training is good, some harder than others. I don't like it all being on line, you can't talk about the course with others and get a better understanding. They (registered person and registered manager) are going to look at putting on a face to face dementia training. There is no more training that I need, we have all the training we need to do a good job."

The environment had limited signage to support people, particularly those who experienced confusion, memory loss or those living with dementia, in orientating themselves around Andrin House Nursing Home. For example, pictorial signs on bathing and toilet facilities were in place and a board in the dining area, providing information as to the day of the week and the weather forecast was in place. The registered manager had ideas they shared with us, about improvements to the environment to support the lifestyle and well-being of those people living with dementia. Their ideas, included the decoration of communal areas to be interactive to provide stimulation for people.

One person when asked about the environment told us, "I am happy with the decoration of my room." People we spoke with noted the recent improvements to the environment. One person told us, "I have seen the difference lately with the bathrooms." (A new wet room had been installed and new sanitary wear had been provided in many toilets.) A second person told us, "My room has been decorated and they have taken me out shopping for new curtains." A third person said, "I have seen changes to the home lately, it was like a tip at the entrance, and now it's clear."

People were confident that their health care needs were met by staff. One person told us, "The staff would take me if I had an appointment, but I pay for the taxi." A second person said, "The chiropodist, optician and doctor come in when needed." A third person said, "My bandage on my leg is changed every other day, it is so much better than when I first came in." A family member expressed confidence that health care advice would be sought should it be needed. They told us, "The doctor would be called straight away if [relative] needed one." Family members also told us that staff kept them informed about any changes to the health and well-being of their relative. One family member said, "All staff are able to tell me how [relative] has been during the day." A second family told us, "Staff would call us, or approach us to tell us if there is any change with [relative]."

People's records included information as to visits from health and social care professionals. The information recorded the reasons for the visit and its outcome. Daily notes and people's care plans showed that the advice given was implemented. For example, where people had been prescribed medication to be taken short term.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation process for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and the nurse on duty, informed us that twelve applications had been submitted. Records showed that independent assessors had visited people, to undertake an assessment following the registered manager's request for a DoLS to be put into place.

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. There were no conditions on the authorisations.

People's capacity to make informed decisions about all aspects of their care had been undertaken. The mental capacity assessment process to determine people's capacity had been clearly documented, including where and how the assessment had been undertaken and by whom. Questions posed to determine people's capacity were recorded along with their responses. Family members, where applicable had been involved in the capacity assessment and their views had been included on the assessment record. Where it had been found people did not have the capacity to make an informed decision, then a best interest decision had been made.

Is the service caring?

Our findings

People had mixed views about staff's availability to spend time with them. One person told us, "Staff don't sit and talk to you." A family member spoke of the support they received from staff. "When I feel down and upset, the staff do notice, they sit me down with a cup of tea, speak to me and make me feel a bit better."

People and family spoke positively of the care and approach of staff. One person told us, "The staff are very kind and caring." A second person said, "95% of the staff are caring." A family member said, "The staff are absolutely caring towards [relative], that is why she is still here." A second family member said, "When I visit [relative], she is always clean and well dressed and cared for." A third family member told us, "Staff are always popping into see [relative], asking if she needs anything or wants to be left alone."

Staff were seen to provide reassurance when people became upset or anxious and we saw staff respond to them in a timely way. A person sitting at the dining table said they were cold, a member of the catering staff placed a blanket around their shoulders. A little while later a member of staff approached the person asking if they had finished their breakfast. The person said they had, however their tea had gone cold, the member of staff brought the person another cup of tea. The person was helped into a comfy chair and the blanket was tucked around their legs as requested and the tea placed next to them on a table.

The registered manager had reviewed the policy for equality and diversity and human rights. Staff we spoke provided examples as to how they provided support to reflect people's diversity by using technology to communicate. For example, using an app on a mobile phone to converse with someone whose first language was not English and supporting the person to celebrate events during the year. Care plans provided information for staff in how to support people's diversity, for example with regards to the religious beliefs.

People and family members had been involved in the development and reviewing of care plans, which meant that were able to influence the care and support. One person said, "I do have a say regarding my care." A second person said, "I am aware of my care plan and I have signed it." A family member said, "I am aware of my [relative's] care plan, I'm happy with it and it has been reviewed."

People shared with us how they influenced their care. One person said, "If I don't want to change from my nightie to put clothes on, I don't have to. It's like being at home." A second person told us, "I have a shower or bath when I want." A third person said, "I choose what I wear, what time I go to sleep and time I wake up."

People's privacy, dignity and independence was promoted. One person told us, "Staff treat me with respect, they knock before they enter my room." A second person said, "I have a phone to keep in touch with the outside world." Family member's also spoke of their relative's decisions and choices being respected. A family member told us, "It's [relative's] choice to stay in her room." People told us that visitors were welcome at any time.

The registered manager had reviewed the policy for privacy and dignity. Staff told us they promoted

people's privacy and dignity by ensuring personal care was delivered with sensitivity, by covering people and by knocking on doors before entering. Staff said they considered the gender of staff when providing personal support.

The registered manager had reviewed the policy for confidentiality and protection of data. All confidential information was held within lockable facilities, to which access was given to those staff involved in the direct care of people. Staff were aware of the need to maintain confidentiality, staff told us due to the nature of their work they were aware of sensitive information, which they knew was confidential. A staff member said, "There are lots of things we know about people here that we need to keep private."

Is the service responsive?

Our findings

At our previous inspection of 23 and 24 April and 2 May 2018 we found the registered person had not ensured that the care and treatment of people was appropriate, meeting their needs and being reflective of their personal preferences. We issued a requirement notice as this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had been made at this inspection.

A new format for recording people's care, support and treatment had been introduced since the CQC inspection of April and May 2018. Care plans for each person, covered a range of topics and were comprehensive, providing clear guidance for staff to follow.

People's care plans provided information provided by the person themselves or that of their family member. Information recorded, supported a person-centred approach to care. For example, providing information as to what clothes people preferred to wear, how they liked their hair to be presented, as to whether they wished to have a light on in their room at night or the number of pillows they had on their bed. Information about their lives prior to moving into Andrin House Nursing Home was detailed for example, information as to their family, work and social activities. People's communication needs were considered, for example if they required to wear glasses, or a hearing aid.

Daily notes recorded the care, support and treatment provided. However, there were many additional records, which staff were required to complete with duplicated information. These records were kept in different files and locations within the service. We found these had not been consistently completed. We found that the person reviewing the care plan had not always referred to all the other relevant documentation. For example, a person with a recent diagnosis of dementia had the specific type of dementia detailed, this was important as different types of dementia have risks associated with them.

A person was noted to display behaviours that challenge due to their dementia. Their care plan stated that a chart should be completed following an incident of behaviour that challenges, to enable an analysis of any triggers or patterns. The chart had not been completed, however there were entries in their daily notes that showed that there were a number of incidents when the person had been reluctant to receive personal care.

A majority of people's care plans had been reviewed accurately and reflected the changes to the people's care and support. For example, when people had been seen by a health care professional who had recommended a course of action. A further positive example, was related to the review of a person's care plan linked to their behaviour and their interests, which had had a positive impact on the person, reducing their anxiety by providing a safe environment for them to walk outside independently.

The registered manager had introduced care groups, which meant an identified member of staff had the responsibility for reviewing and updating the care plans of people within their group. We found this had been implemented and the records we viewed, showed people's assessments, risk assessments and care

plans had been developed and reviewed by the same member of staff. This provided continuity and helped develop relationships with people using the service and family members who had been involved in the assessment process and had signed the care plans.

People spoke to us about how they spent their time. One person said, "There are activities downstairs, I never go down to them, my choice and they don't come to me." A second person said, "I stay in my room and watch television, do my word books and read the paper." A third person commented, "I spend my day doing what I love, drawing." People spoke of the support provided by staff to enable them to pursue their interests. One person said, "The staff would bring me a newspaper and anything I ask from the shops, nothing is too much for them to do for me." We spoke with family members about their observations of people's involvement in activities. A family member told us, "Staff used to support [relative] with activities when she was able." Family members did comment that activities had not taken place with such frequency recently, as the activity co-ordinator who was also a senior carer had been working with the registered manager to review people's needs and develop care plans.

People also told us that the activities provided were not of interest to them. A person told us, "I think that the activities suit the majority of residents here but not for me." A person told us how they were supported to go out, however they wished to be supported to go out more often. They told us, "They (staff) take me to town, but not often enough."

On the second day of our inspection visit, staff encouraged a group of people to take part in 'batting a balloon', which was enjoyed by those involved. People were seen to read newspapers. Music was playing, for much of the time we were at the service. Staff were seen to sit with people and talking with them on a one to one basis.

People's care plans, in some instances, detailed their wishes upon their death held within a funeral plan. For people who did not wish to be resuscitated, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms recorded their wishes, and had been signed by the appropriate health care professional and were kept at the front of the person's records. To support end of life care, 'anticipatory medicines' were prescribed and these medicines were in place should they be required to manage their symptoms and pain.

The registered manager had signed up to attain the Derbyshire End of Life Quality Award (DELQUA) qualification, they told us they had had their first meeting with the external organisation, Southern Derbyshire Clinical Commission Group.

People were knowledgeable and confident about making a complaint. One person told us, "I know how to complain but never had to and have no concerns." A second person said, "If I had a concern, I would speak to [nurse]." A third told us how they had raised a concern and it had been addressed. They said, "I have complained about a member of staff being nosey, looking in my belongings, she does not do it anymore."

Family members told us whilst they had not made a complaint, concerns they had brought to the attention of the registered manager had been listened to and action taken. For example, the external staff smoking area had been moved to alternative location to prevent the smell of smoke entering the service.

The registered manager had reviewed the complaints policy and procedure. Information about making a complaint was displayed on a notice board, however this did not provide contact details for the service, provider or external organisations as referred to in the policy. There had been no complaints raised with the registered manager since our earlier inspection of April and May 2018.

Is the service well-led?

Our findings

At our previous inspection of 23 and 24 April and 2 May 2018 we found the registered person had not complied with their conditions of registration as a registered manager was not in post. We issued a requirement notice as this was a breach of Regulation 5 of the Registration Regulations 2009 (Schedule 1) Registered manager condition. We found improvements had been made at this inspection.

Andrin House Nursing Home had a registered manager in post as a result of a successful application to the Care Quality Commission, following the CQC inspection of April and May 2018.

The registered manager had a good understanding of the requirements of their registration with the Care Quality Commission and necessary notifications had been made to the CQC.

At our previous inspection of 23 and 24 April and 2 May 2018 we found the registered person did not have in place systems to ensure good governance of the service. was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found improvements had been made at this inspection.

We found improvements were still needed to ensure audits were comprehensive and identified any shortfalls, so as improvements could be made. For example, the registered manager undertook an audit of people's care plans to ensure they were being regularly reviewed. However, the audit had not identified that people's supportive records, including charts were not being consistently completed by staff. Neither had the audit identified that the reviewing of the person's care plan by nursing and senior care staff, had not considered all the information documented by staff. A further example was, the audit for medication undertaken by a nurse had not identified that protocols were not in place for everyone who was prescribed medicine to be taken as and when required.

We spoke with the registered manager, who confirmed they had not reviewed the use of additional charts and documents for staff to complete. The registered manager said they would review all documentation and simplify the process, to make it easier for staff to record information, and for that information to be reviewed.

The provider is required to display the rating from inspections awarded by the Care Quality Commission (CQC), both within the service and where applicable on their web profile. The provider had displayed their rating within the service on a notice board and on their website. Family members we spoke with were aware of the rating awarded at the previous inspection of April and May 2018.

A staff meeting had been held to discuss the CQC inspection report, following the inspection of Andrin House Nursing Home in April and May 2018. Minutes reflected the concerns highlighted by the inspection and acknowledged that the shortfalls were a result of poor leadership and ineffectual governance. The provider had thanked staff for their hard work and had outlined with staff the improvements required.

Following CQC's inspection of April and May 2018, the provider had engaged the services of a healthcare management consultancy firm. The registered person told us their involvement was to support them in improving the service and that they planned to retain the services of the consultancy firm for a period of twelve months. The registered person said they continued to work with the consultancy firm in developing effective governance systems, which included processes to assess the quality of the service provided.

The registered person visited the service and reviewed the quality assurance audits undertaken by the registered manager. Regular meetings were held between the registered person and registered manager, with records kept of their meetings.

The registered manager upon their appointment had circulated questionnaires, to people using the service, family members and staff. The purpose was to identify a benchmark of people's views to enable them to identify areas for improvement. Questionnaires focused on four key areas, the care of people, organisation and management, people's views and development and learning. The results from surveys had been analysed. Positive feedback included, staff working as a team, the care of people and people's satisfaction with the service. Areas identified for improvement included, focusing on communication between the registered person, registered manager and staff, improvements to the environment and equipment and staff shortages.

The registered manager had made improvements. For example, they had identified staff shortages were in the main due to staff sickness, particularly at the weekend, this had been addressed individually within staff supervision. The registered manager said this had reduced the level of staff absence due to sickness. Communication had been improved by the introduction of regular staff team meetings, supervision and appraisal. Key areas of responsibility had been identified in four areas, each key area was to be led by a named member of staff, who had responsibility in making links with external organisations and sharing information amongst the staff team.

Environmental improvements had included new windows to some areas, the installation of a wet room and new sanitary wear in some bathrooms and toilets. Decoration, including replacement of floor coverings had taken place in some areas with additional improvements planned.

Opportunities for people and family members to comment and contribute to the day to day running of the service, through meetings and the seeking of views had been provided. Family members told us, "There are resident's meetings, they give us a chance to come up with new ideas. Not many attend though." A second family said, "I have seen suggestions made come to fruition." A third member told us, "Any questions we ask are answered or clarified, especially relating to extra care. I feel supported, unfortunately we cannot attend meetings as the time is when we are at work."

Policies and procedures had been reviewed, records we viewed, discussions with staff and our observations evidenced that these were implemented. The registered manager had a good understanding of the requirements of their registration with the Care Quality Commission. Where necessary, the registered manager had undertaken investigations into incidents and accidents as part of their audit system.

The registered person and registered manager were receptive to our feedback and comments following this inspection and spoke of their commitment to continue in further developing the quality of the service provided. The registered person and registered manager, with the support of the consultancy firm were looking to prioritise further plans for improvement, based on risk, detailing the improvement, how it was to be made, the person with the overall responsibility and the timescale involved. The plan would be regularly reviewed by the registered person and registered manager, within their meetings.

The registered manager was looking to gain external accreditation to evidence the quality of the service. In addition to working towards attaining the Derbyshire End of Life Quality Award (DELQUA) qualification, they had plans to attain the Dignity Champions Award.

As part of the inspection, we looked at the records of audits undertaken by external stakeholders. An independent audit had been carried out on the medicines held within Andrin House Nursing Home in July 2018. The report had found recent improvements in the management of medicines, which included a new storage area. An audit by the Food Standards Agency in July 2018 had awarded a food hygiene rating of level 5. (The ratings go from 0-5 with the top rating of '5' meaning the service was found to have 'very good' hygiene standards).