Touray & Co Limited

Highfield House

Inspection report

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Date of inspection visit:
08 August 2016
09 August 2016
20 September 2016

Date of publication:
17 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 and 13 April 2016, at which we found a breach of legal requirements related to the governance and management of the home. In particular we found issues related to the checking and auditing of the care and environment at home and the oversight of the service by the provider. We took enforcement action against the provider and issued a warning notice.

We undertook a further inspection on 8 and 9 August 2016 to check that they had acted on the requirement of the warning notice and to confirm that they now met legal requirements. We had also received information of concern from other professionals who had visited the home and so spent time looking at other areas of care and service provision. We again visited the home on 20 September to further review actions taken by the provider. We also wrote to the provider seeking clarification on actions taken and documentation related to the running of the home.

This report only covers our findings in relation to this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Highfield House' on our website at www.cqc.org.uk'

Highfield House is a nursing home located in Bedlington, Northumberland. It is registered to provide accommodation with personal care for up to a maximum of 27 people. At the time of the inspection there were 16 people living at the home.

A registered manager was not in post at the home at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. An acting manager was in charge of the home during the inspection and he supported us on both days. We were also supported by the provider on the second day of the inspection.

At the previous inspection we noted that no fire drill had been undertaken at the home in recent months. At the inspection on the 8 and 9 August 2016 we could find no formal record that a drill had been completed, although the acting manager and staff said there had been a drill, but it had not been recorded. At our visit on 20 September 2016 we saw a drill had been undertaken, but had not occurred until 15 September 2016. We also found that risk assessments for individuals related to fire safety had not been updated in line with the set review date.

At the inspection in April 2016 we found that accidents and incidents at the home were not being regularly reviewed, to identify any patterns or concerns. At this inspection we found that, whilst accident records were being completed there continued to be no review of the events to help improve safety at the home.

We had also previously found issues with the safe management of medicines at the home. In particular we found records to ensure safe recognition of people when giving medicines were not well maintained, care plans for "as required" medicines were not appropriate and temperatures in the room where medicines were stored was not regularly monitored. At this inspection we found new identification sheets had been developed and revised "as required" medicine care plans had been rewritten. Whilst room temperatures were being monitored we noted that the temperature in the clinic area was regularly above recommended levels and only limited action had been taken to address this. At the inspection on 20 September action had been taken to address the temperature issues in the clinical room.

Safety certificates to show that equipment used at the home was well maintained and safe to use had not been previously available. At this inspection these certificates were in place and available to view. At the previous inspection we had highlighted concerns about the cleanliness of certain areas of the home, including the laundry area. At this inspection we saw significant improvements had been made to the laundry area and the sluice areas. The home had been working with the local infection control service to improve overall cleanliness. However, on our return on 20 September 2016 we found that three of the four laundry machines were broken and washing had been hung in empty rooms to dry and air.

A number of new nursing staff had been employed at the home. However, it was not always possible to determine from records whether appropriate Disclosure and Barring Service checks had been undertaken.

We had raised concerns at the previous inspection in April 2016 that consent was not always sought in line with the provision of the Mental Capacity Act (2005). At this inspection we found there were still inconsistencies about how consent was gathered or how decisions about people care were made when they were unable to give consent.

The acting manager had reviewed staff training needs and was developing a training strategy. Staff had been formally signed up with the local learning development unit to access training. People continued to be supported to access health services and sufficient food and fluids were available.

People told us that they continued to feel supported and care for by the staff at the home and we witnessed good relationships and interactions. We highlighted with the acting manager some practices that could be improved to support people's privacy and dignity.

At the previous inspection we found that care plans were in the format of the previous provider. We were told these were in the process of being reviewed. At this inspection we found there had been limited reviews of people's care and the majority of plans had not been updated, although monthly reviews of care records were being undertaken. Where plans were updated they did not always reflect people's full needs. The provider had dealt with a number of complaints and concerns since the last inspection and where necessary made alerted the local safeguarding adults team.

At the inspection in April 2016 we had found that there were no consistent checks and audits being undertaken at the home to ensure that the care and the environment were safe. At this inspection we found there remained very limited audits in place, although the acting manager told us he regularly walked around the home to carry out visual checks. The provider told us they had not been overseeing the home as closely as they would have liked, but had plans to improve their monitoring visits in the coming months. We had also previously found that records were not effectively maintained or stored securely. At this inspection we noted this had improved and older records had been archived appropriately.

We found five breaches of regulations. These related to person centred care, need for consent, safe care and

treatment, good governance and fit and proper persons employed.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was no initial evidence that a recent fire drill had been undertaken or conducted in in an appropriate manner. Falls and accidents had not been regularly reviewed.

New "as required" care plans had been out in place for certain medicines. Some daily audits of medicine were evident but had not been applied consistently. At the initial inspection the temperature in the clinical room was regularly above the recommended safe storage temperature for medicines.

Recently appointed staff had not had live Disclosure and Barring Service checks in place when initially working at the home. Some improvements in the cleanliness of the home had been made and safety certificates were available to view.

Is the service effective?

Requires Improvement

The service was not always effective.

The acting manager had commenced a review of staff training and some training had been undertaken. There was evidence of some supervisions but annual appraisals had not yet been scheduled.

Best interests decisions, to protect people from unlawful restraint with bed rails and lap belts had not been updated or did not meet the requirements of the mental capacity Act (2005).

People were supported to access regular food and fluids.

Is the service caring?

Good

The service was caring

Staff attitudes to people and their approach was patient and caring. Staff responded appropriately to people's day to day needs.

Some actions did not always protect people's privacy and

dignity. Some staff sat to take their breaks in the main lounge, where people were resting, rather than in a designated staff area.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs had not been reassessed. Care plans had not been revised and updated and where work had been carried out on care plans they did not always cover all aspects of people's care needs.

Risk assessments were reviewed monthly, but information contained in the reviews was limited and did not always reflected identified risks.

Is the service well-led?

Inadequate

The service was not well led.

There had been no substantial audits undertaken since the previous inspections, despite the assurances by the provider that these were in place. Where audits had been undertaken they were not completed regularly or consistently. The provider had not undertaken significant oversight of the service.

There were no clear system in place to ensure nursing staff had access to clinical supervision and oversight. Some staff said the felt supported by the acting manager and there had been some improvements at the home.

Highfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 undertook an unannounced inspection on 8 and 9 August 2016. This inspection was to check the provider had taken action to address breaches we had previously identified and enforcement action we had taken. We had also received information of concern from local professionals who were visiting the home.

The inspection team consisted of one inspector.

As this was an inspection to follow up previous breaches of regulations we did not request provider information return (PIR). Before the inspection we reviewed the information we held about the home.

We spoke with two people who used the service to obtain their views on the care and support they received. We talked with the acting manager, the provider, one nurse, two care workers, a domestic worker and the cook. We also spoke with a health professional who was visiting the home during the inspection. Subsequent to the inspection we met with the provider and the provider's nominated individual.

We observed care and support being delivered in communal areas, including lounges and dining rooms, looked in the kitchen areas, the laundry, clinic rooms, bath/shower rooms and toilet areas. We checked people's individual accommodation. We reviewed a range of documents and records including; five care records for people who used the service, five medicine administration records; four records of people employed at the home, duty rotas, complaints records, accidents and incident records and a range of other management and care records.

Inadequate

Is the service safe?

Our findings

At our inspection in April 2016 we noted a number of concerns with regard safety issues at the home.

At the inspection in April we noted that there had been no fire drill performed at the home since the provider had taken over the location in November 2015. The home's fire safety register showed no further fire drill records since the last inspection. We spoke with the acting manager about this. He said he was unsure whether a drill had taken place. We asked the home's nominated fire safety officer. They told us they had conducted a drill a few weeks previously, but had not written it down, they were unable to recall the date of the drill. On the second day of the inspection the acting manager told us the date of the drill had been written on the kitchen calendar as 21 July 2016, but had not been formally recorded in the home's fire safety records. We asked the provider about fire drills at the home. She told us she was sure a drill had also been undertaken by a director of the company, but was unsure when this had taken place. This meant we could not be sure appropriate fire drills had taken place to ensure the safety of people and staff at the home and assess any risks associated with an evacuation of the building. A record of the drill and any action needed had not been maintained. On our return to the home on 20 September 2016 we found a fire drill had now been undertaken, but not until 15 September 2016. A record of staff in attendance had been kept and an indication of the time the drill took place. However, there was no information on how the drill was performed and any actions that needed to be followed up.

Fire risk assessments for people living at the home had been due for review in May 2016, but this had not taken place. These documents identified the risks people may face in the event of a fire. We spoke to the acting manager about this and saw staff were updating these assessments on the second day of the inspection.

We also noted at the inspection in April that no review of incidents and accidents had taken place since January 2016. Reviews of such events help to learn lessons to prevent future accidents and to identify trends. The provider had written to us and told us that there was now a monthly review of incidents and accidents at the home. We found there had been 15 recorded events since the last inspection, and whilst the majority of incidents were minor in nature, we could find no evidence of any monthly reviews. We asked the acting manager about reviews of accidents. He told us he had only started at the home in June 2016, but had not undertaken any reviews since he had taken up post. This meant that despite previous reassurances from the provider, risks associated with people have in falls or other accidents had not been reviewed to identify action to prevent future similar events. A review of incidents between the 8 August and 19 September was available at the inspection on the 20 September.

In April we had raised concerns about the safe management of medicines at the home. We noted that medicine administration records (MARs) did not always have effective identification to ensure that people received the correct medicines. We also noted that some people were receiving "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. However the care plans and instruction for the use of these medicines were not always clear. At this inspection we found that people now had identification sheets related to their MARs to ensure the correct medicine were given. New "as

required" care plans were in place utilising a format provided by a national company.

Also at the previous inspection we noted that temperatures in the room used to store medicines was not always monitored, to ensure medicines were kept appropriately and safely. At this inspection a system had been established to monitor these temperatures. However, we noted that there were several days when the temperature was recorded as being above the recommended 25 degrees Celsius, including days when the room temperature was recorded as 30 degrees and 32 degrees, which had occurred in July 2016. Whilst a fan had been placed in the room this was ineffective. The temperature in the room on the day of the inspection was 27 degrees. We spoke to the acting manager about this. He said that he was looking to order an air conditioning unit for this room. This meant prompt action to ensure the safe storage of people's medicines had not been taken. At our inspection on 20 September 2016 we noted that regular monitoring of temperatures had been maintained and a device had been installed in the room to help regulate the temperature.

A daily audit had been introduced for nursing staff to monitor that MARs were up to date and that people's medicines had been given correctly. We saw that this was carried out inconsistently and whilst we could see that some actions had been completed we could not confirm this for all the actions noted. We also saw a number of errors or inconsistencies on MARs, including gaps in recording and some medicines not always recorded as being given in line with instructions. On the 20 September we were shown a new audit process that had been introduced. Whilst this was regularly completed, the information was limited. For example, the form highlighted that some signatures were missing from MARs, but did not indicate which MARs needed to be updated.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

At the time of the inspection a representative for a national pharmacy company was speaking to nursing staff about the introduction of a new medicines management system. We were also aware that a pharmacist from the local Clinical Commissioning Group was also going to review medicines at the home and provide an action plan for improvements.

At the time of the previous inspection the provider had not appointed any new staff. Since this inspection the provider had appointed three new nursing staff and one care worker. We found that practices in relation to safe recruitment were not always followed. We could not be certain that all the nursing staff had been subject to full and appropriate Disclosure and Barring Service (DBS) checks. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. Records were unclear and checks on the DBS website were unable to confirm that valid checks were in place. Where DBS checks were in place some staff had items highlighted on the check documents. Whilst these were highly historical in nature and related to juvenile incidents, no risk assessments had been undertaken to ensure that the person remained appropriate to be employed. We could also find no evidence that checks had taken place, such as copies of passports or utility bills being seen to confirm people's identity. We noted that some references for nursing staff had been from friends or colleagues, rather than employees or managers. The acting manager told he was aware of this and there was evidence of additional references being sought subsequent to staff appointments. The provider subsequently wrote to us giving details of when staff had received confirmation of their DBS clearance. This showed that at the time of our original visit to the home on 8 and 9 August 2016 there were three staff employed who did not have up to date valid DBS clearance. This meant that appropriate and robust systems to ensure staff were recruited effectively were not in place.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19. Fit and proper persons employed.

At the previous inspection the manager in post at the time could not provide copies of safety certificates for the home, such as gas and electrical systems, Portable appliance testing (PAT) and Lifting Operations and Lifting Equipment Regulations (LOLER) certificates. Following the inspection the provider sent us copies of these certificates and we saw at this inspection they remained valid.

We had also highlighted concerns about cleanliness at the home, particularly in relation to the operation of the laundry, some waste bins and light pull cords not being clean. At this inspection we saw the provider had taken a range of action to address these matters. Light pull cords had been replaced with items that could be cleaned effectively and waste bins had been replaced. The two laundry areas of the home had been cleared of all linen and additional items and were clean and tidy. A separate room had been established for the storage of clean laundry and clothing. A new sluice room had been developed and in the old sluice area a bed pan washing machine had been installed. General cleanliness of the home was good, with bathroom and toiles clean and tidy. We noted some transient odour around the home and there remained some odours in some bedrooms. The acting manager told us that a specialist carpet cleaner was due to visit the home the following week. T our inspection on 20 September 2018, we found that three of the four pieces or laundry equipment were out of order and clothing was being tried in empty rooms and in one of the lounge areas. The manager told us that all three machines had failed recently and an engineer had been called and was awaiting parts. This information was confirmed by domestic staff at the home.

We were aware from the local authority that a number of safeguarding issues had been alerted to them and these were being investigated. The provider had notified the CQC of these events and was working with the local authority to examine and resolve these matters. We will consider any regulatory action and report on these matters in the future, if required.

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.

At the previous inspection in April 2016 we saw that some people's files still contained consent forms signed by their relatives from the time of the previous provider. There was limited evidence to demonstrate that people's capacity to make their own decisions had been assessed and, where they were unable to make decisions for themselves, limited evidence of best interests decisions being made in line with MCA guidance. At the time the provider told us this would change as new care documentation was brought in and care plans reviewed. At this inspection we found there remained a lack of evidence that people's rights to make their own decisions were being protected and that best interests decisions were being made. We found people with bedrails in place or were wearing lap belts when in wheelchairs. Whilst these items were for their safety, under the MCA they are considered forms of restraint and require consent or a best interests decision for their use. We spoke with the acting manager about this who agreed that best interests decisions should have been carried out but had not been undertaken. He said he would address this as soon as possible. However, on the following day he showed us consent forms signed by relatives for people who did not have capacity to make decisions. This action was not in line with the MCA guidance. This meant proper processes were not in place to ensure people's rights were protected. The acting manager subsequently found a document that he said he would adapt to meet the MCA requirements for best interests decisions.

At the inspection on 20 September 2016 we found documentation relating to consent or best interest decisions did still not meet the requirements of the MCA. Best interests decision documentation did not always explore the least restricted option and we found there were still consent forms, signed by relatives, for matter such as the giving of flu vaccinations.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11. Need for consent.

Where people did have capacity to make their own decisions there was some evidence that they had agreed to actions and consent forms had been completed. Applications for DoLs were in progress and were being monitored to ensure they were reviewed and revised, as necessary.

At the previous inspection there was some evidence of staff training, but there was no formal system to review what training staff had and what needed to be updated. At this inspection the acting manager told us

he was currently reviewing all staff training to produce a full overview. We saw evidence that he had reviewed current training undertaken and was planning future training needs assessment. There was also evidence of ongoing training and additional updating from local professionals. The acting manager told us that all staff at the home had now been registered with the local learning and development unit and showed us the system on the computer. Staff confirmed they had undertaken a range of training since the previous inspection. A visiting health professional confirmed that staff had been provided with a range of additional training or skills development. They told us, "We are working together. There has been a big explosion of learning over the last few months." This meant that staff were supported to update their training and continue with their professional development.

The acting manager and provider told us that some staff supervisions were continuing. Because of the change in staffing and with a new manager coming into the service, there had been no recent update of annual appraisals, although the manager was aware that these needed to be completed.

People continued to be supported with their health and well-being. There was evidence in care files and records that they had been seen by general practitioners or other local health professionals. We spoke to a specialist nurse who was attending the home during the inspection. They confirmed that they visited the home weekly and helped to review people's health needs. They also told us that a practice nurse from a local GP surgery also attended weekly to help review people's health needs. There was evidence that other specialists had visited the home to assess and review people's health needs and provide advice or treatments.

At the previous inspection we had found that people were supported to maintain their dietary and fluid intake. At this inspection we found that people continued to be supported with meals and drinks. Information from a local authority visit had raised some issues around how people with diabetes were being supported. We asked the cook specifically about this matter and they reassured us that they had access to specialist ingredients and food stuffs to support people who were diabetic.

Good

Is the service caring?

Our findings

At the previous inspection in April we had had rated this domain as Good. We had seen that people were supported in a caring manner and there appeared to be good relationships between people and staff. People had commented at the time that they felt the staff at the home were caring. At the inspection on 20 September 2016 we noted there was a complaints/ compliments book placed in the entrance hall of the home. We saw there were four recent entries in the book, all praising the kind and caring attitude of the staff at the home.

At this inspection we saw a similar situation, with staff responding to people's needs on a day to day basis. We witnessed staff members sat having conversations with people and also sharing jokes with them. Where people became upset or distressed staff responded fittingly and gave good reassurance to them, including appropriate physical reassurance, such as hugs or holding their hands. People we spoke with told us that the staff were friendly and attentive to their needs.

On 8 and 9 August we witnessed some instances which did not always offer people respect and privacy in the daily lives. For example, we saw that some staff sat and took their breaks in the main lounge area and were sat chatting between themselves, whilst people were watching television or speaking to others. For people who use the service the lounge area was an important part of their home. Staff taking breaks in this area meant people's privacy in their own home was disturbed and disrupted. We also witnessed an incident where a person was presented with a piece of cake along with a cup of tea and saw the cake was placed on the table, rather than presented on a plate. We asked the care worker to provide the person with a plate and they immediately brought some plates from the kitchen. We spoke to the acting manager and provider about these incidents. They agreed these actions did not support people's privacy and dignity and said they would address the issues with staff immediately.

We also saw actions supportive of people's privacy and dignity. We witnessed a nurse discretely ask a person if they required any extra medication to help with their bowels and whether they wished to take some medicine for pain relief. The nurse staff member did this is such a way as to ensure the conversation was not overheard by others and was discrete. This meant nursing staff made efforts to ensure people's dignity was respected and maintained.
At our inspection on 20 September 2016 we did not witness any specific events that did not support the dignity and respect of people living at the home.

At the previous inspection people and relative had told us they were involved in helping determine their care. People we spoke with told us that staff spoke to them about their care. The provider said she had met a number of relatives when she had been visiting the home and the acting manager told us that relatives would just speak with him if they wished to discuss any care matters. We noted there had not been regular meetings with relatives or people, although the provider told us that a meeting with relatives, which would include representatives from the local safeguarding team, was planned for the near future, to explain the work being undertaken to support the home.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in April 2016 we saw that care plans were still in the format of the previous provider and had not been significantly updated. The provider told us at the time that the intention was to introduce a new care plan system and review plans as this was introduced. At this inspection we found that there had been little progress made in this matter. The acting manager and provider told us a considerable amount of time had been taken sorting out the care plans to bring them into some sort of order and that this meant that reviews of care had not taken place.

Two care plans were in the process of being rewritten, although were only partially completed. We found that the details in the care plans were not always comprehensive and did not always reflect the full needs of the person concerned. For example, we saw one person's medicines care plan stated that they were compliant with taking medicines and had no problems swallowing them. However, elsewhere in their care documents there was reference to them having potential swallowing difficulties and also to frequent bouts of vomiting, due to a physical condition. We spoke to the acting manager and a nurse about this. They said that they person had recently been assessed by the speech and language therapist (SALT) and had been deemed not to be a choking risk or have significant swallowing difficulties. However, there was no evidence in the person's care file to say that this visit had taken place or what the outcome of the assessments was. The manager told us he had spoken to the SALT who had told him the report was being posted across top the home.

We looked at the person's care records and saw that in the previous eight days there had been five recorded incidents of the person vomiting. Because the care plans relating to their medicines did not reflect this condition, there were no clear instructions for staff to follow if the person vomited soon after being given their medicines and what action staff should take to ensure important medicines and any pain relief was effective. This meant the person's care plan was not always comprehensive and did not always support their identified needs. The nurse acknowledged that the care plan needed to be more comprehensive and immediately rewrote the plan to take account of all the aspects of the person's condition that may affect them taking their medicines.

We saw in another care record that a person, whose weight had been stable for a long period, had lost significant amount of weight in the last month. We could find no evidence in care records to say that this had been monitored or discussed with health professionals. We spoke to staff and the acting manager about this. The acting manager told us he was unsure why this issue had not been raised or followed up. Staff told us the person had been admitted to hospital on an unrelated matter, but were sure that issue would have been looked at if the person was still at the home. We could not be certain that the matter would have been followed up had the person not been in hospital.

At the inspection on 20 September 2016 we asked the provider to show us care records that had been reviewed and updated. One of the care plans presented to us identified that a person required drinks to be thickened, although they could manage to eat food normally. A letter from the SALT service recommended that tablets should be taken in thickened juice or a spoonful of yoghurt. There was no information in relation

to this approach in the person's medicines care plans, although nursing staff were aware the person could sometimes choke. This meant the person's care plan was not always comprehensive and did not always support their identified needs.

People had risk assessments in their care plans to monitor risks associated with issues such as falls, choking or skin integrity concerns. Whilst these were completed monthly they were in the main, tick box in style and did not give a full over view of the person's current needs or any change in their condition. The individual who required thicken fluids to support them when drinking and when taking medicines had been assessed as managing unaided with eating and drinking issues and rated a as a zero risk. This meant that risk assessments did not always identify risks to people's health and well- being.

Care plans we looked at had been reviewed monthly and were mostly up to date. However, because they were in the old provider's format it was not clear if the identified needs were current and had been fully reviewed. Reviews of care were sometimes limited and contained phrases such as, "care plans remains appropriate".

We spoke with the acting manager and provider about the care plans. They agreed that the reviews of people's care had not taken place as quickly as they had intended, because there had been so many aspects of the home and it's running that they needed to address. They agreed that reviewing people's care and care plans was important and needed to be undertaken as soon as possible. The provider told us she would speak with the nursing staff about this.
At the inspection on 20 September 2016 we found that some care records had been updated but many remained in the previous provider's format. Records that the provider told us had been reviewed and updated continued to have elements in the old provider's format that did not reflect current needs.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person-centred care.

At the last inspection we saw that staff had a good understanding of people as individuals. Staff we spoke with at this inspection continued to demonstrate a detailed knowledge of people's daily life, background and family life. Care staff told us they acted as key workers for certain people and contributed to the reviews of care and in delivering individual care. A visiting health professional told us they were impressed with the care staff and their knowledge of people and their care needs. They said they felt that the consistent and knowledgeable approach from care staff had helped sustain the service during the recent period when nursing staff levels had required regular agency use.

The provider had dealt with a number of complaints and concerns since the last inspection. We saw that these were either on-going or had been dealt with appropriately and where necessary action taken to refer maters on to the local safeguarding team for further investigation.

Inadequate

Is the service well-led?

Our findings

At our inspection in April 2016 the previous manager had told us that she had failed to carry out a range of audits and checks on the building or the care of people living at the home. We also noted that oversight from the provider, to ensure that regulations were complied with, had been limited. The provider had told us that she would be introducing a range of checks and audits to ensure the safety of people at the home and the effective running of the service. We issued a Warning Notice in relation to Regulation 17, Good Governance and told the provider they must take steps to improve this area and meet regulations. As part of the action plan the provider sent to us she stated, 'Audits now in place to monitor cleanliness, medication, care planning and general quality of service at the home, these are reviewed monthly.'

At the inspection on 8 and 9 August we found there remained limited or no systems in place to audit and check on the running of the home and to provide management oversight by the provider. Daily medicines audits had been introduced and there was some evidence that actions from these checks were being undertaken. For example, some audits highlighted missing signatures on MARs and we noted these had been corrected. However, this was not consistent and there were other actions that we could not confirm had been completed. There was a single audit related to the cleanliness of the kitchen at the home, undertaken in July 2016. There was no other written evidence to indicate that regular checks on the home were being undertaken by the acting manager or the provider. Other aspects of the warning notice had not been complied with, in that regular checks on clinical room temperatures had not been acted on and there was a lack of clarity regarding fire drills being undertaken.

The acting manager told us that he did make regular checks on the home and undertook daily walks around the building, but did not formally audit or check on aspects of the service and did not record actions points. He showed us a document he was about to introduce to record these regular checks, but agreed that none had been complete at the current time. The provider told us she did not carry out regular checks to ensure that any actions required were being followed up. She said that recent weeks had seen her having to concentrate on other matters and that she had not been able to visit the home on a regular basis, as she would have liked. Both the acting manager and the provider confirmed they were in contact by telephone during this period. This meant there continued to be no regular and effective management oversight of the service and no checks on the safety and appropriateness of the service.

At our visit on 20 September 2016 we found that a number of audits had been put in place, although we could not always verify how and when the audits had been completed. For example, a monthly audit of mattresses in use at the home was dated as 19 September 2016 on page one, but had the date June 2016 on the second page. A document entitled provider audit had been completed by a member of staff at the home. The provider agreed that she had not undertaken the audit as she should have done. We asked the provider how she ensured that care plans had been updated and care needs reassessed. She told us there were lists in the front of each care records highlighting what needed to be actioned. We found these lists were rough hand written lists that were either scored out or ticked, with no indication of the date items had been complete and by whom. This meant we could not be sure that audits and checks put in place were effective and properly monitored and reviewed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.

The acting manager told us he was not a nurse by background and felt that as the location was a nursing home it was important to have robust nursing advice and clinical skills available. He said that whilst the nurses at the home were supportive and were able to offer advice on more complex clinical issues, and there were a number of outside professionals who came into the service, it was important to have dedicated senior nursing time. He said he had spoken to the provider about this and some additional hours were being made available. We spoke with the provider about this matter. She agreed that a lead nurse or clinical lead was required for the home, but said she had not been able to appoint anyone currently. She also told us that she was a qualified nurse and could also be contacted for support and advice if necessary. Subsequent to the inspection the provider told us that she was going to be taking a more direct role in the running of the home and would be able to provide the necessary nursing oversight.

At the inspection in April 2016 we saw that records related to both people using the service and staff were not stored securely or effectively. We found large numbers of records in unsecured drawers and confidential records, that stated they should be kept securely, not locked away. At this inspection the manager told us that a large number of old records had now been archived and were stored in a locked area. We found that records were store in better order. However, we noted that the office area, which contained people's care files, was not always secured when not in use. This meant care records were not always kept securely.

Staff we spoke toon 8 and 9 August 2016 were more positive about the home and the support from management than when we spoke with them in April 2016. Staff said that the uncertainty of recent months had reduced and they felt the home was starting to improve. The said the acting manager was very approachable and they could raise matters with him. They also said there had been some staff meetings when they had been able to raise issues or discuss improvements. One staff member told us, "(Acting manager) is okay; no problems. I'm able to go to him if I have any concerns. Things are settling down now and working out. We are able to work closely together with the nursing staff now." A visiting professional told us, "We are making progress. It seems to be going in the right direction. There are no particular patients that I am worried about. What is mainly needed is continuity." At the inspection on 20 September 2016 staff were less positive about the atmosphere at the home and felt morale had dipped over the intervening weeks.

Subsequent to the inspection on 8 and 9 August we met with the provider and the provider's nominated individual. They told us they acknowledged that systems had not been in place to effectively manage the home. They said they had a range of systems that they were now putting in place to effectively monitor the improvement in care. The Provider also told us she was going to take more hands on approach and be at the home on a more regular basis. At the inspection on 20 September we found that the system put in place were not always effective or were not fully monitored to ensure people's care was safe and appropriate and regulations were met.
This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.