Huddersfield Nursing Homes Limited

Newsome Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection of Newsome Nursing Home took place on 2 June 2015 and was unannounced. The service was inspected in August 2014 and found to be in breach of the management of medicines and supporting workers. At a follow up inspection in February 2015 we found that although the medicines management had improved, staff were still not being offered regular supervision or appraisals. An action plan was received on 11 March 2015 detailing that regular supervision was to take place and appraisals to have taken place with all staff by 30 June 2015. During the inspection we found that this had been addressed and all actions were completed.

Newsome Nursing Home is a registered nursing home in a quiet residential area of Huddersfield. The home provides accommodation for up to 46 residents with residential, nursing and dementia care needs. The home consists of two linked houses; Newsome Court and Newsome Lodge. The ground floor of Newsome Court is dedicated to the care of people living with dementia. Accommodation in both houses is provided over three floors, which can be accessed using passenger lifts. There are secure gardens which provide a private leisure area for residents.

Summary of findings

People told us they felt safe and we found staff were able to identify factors which may be deemed to be safeguarding and were aware of how to act in such situations. However, we did not always observe staff respond appropriately to potential safeguarding situations. We found that risk was assessed thoroughly but not always recorded correctly. Staff received an appropriate induction and had been subject to robust recruitment procedures.

We found that people's medicines were administered safely and records kept in accordance with the National Institute for Clinical Excellence (NICE) Guidance: Managing Medicines in Care Homes. There were effective links with GPs and other health professionals to ensure that people were receiving timely input of external healthcare professionals.

Staff received regular supervision and appraisals. They also had access to relevant training for their roles. They demonstrated understanding of how to comply with the requirements of the Mental Capacity Act 2005 by seeking consent before undertaking care tasks.

People had support with eating and drinking although we asked the registered provider to consider alternative cups to promote people's dignity. This extended to protecting people's privacy where doors were not always closed prior to undertaking personal care tasks. Call bells occasionally took some time to be answered.

We found some staff were not pro-active in supporting people with their care needs and one person's expressed wish to return to their room was ignored on more than one occasion.

The activities co-ordinator was a positive asset to the home, providing some meaningful engagement with as many people as possible. They ensured people were encouraged to join in where they wished and undertook a range of activities.

We were concerned at the existence of two concurrent recording systems, one paper and one electronic. The registered manager informed us the service was in a transitional period of implementing the new electronic system. However, this transition over a two month period had the potential to lead to errors and omissions in people receiving the correct support and we requested the registered provider deal with this a matter of urgency.

The home had a registered manager who we found was supportive and liked by people and staff alike. 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.

There were some audits in place but because of the risks associated with having two sets of care records, we felt these were not robust enough.

We found breaches in regulations 10,13,14 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always safe as staff did not always demonstrate awareness of their responsibilities in regards to safeguarding people.

We saw evidence of thorough risk assessments in people's care records although there were issues in that the transfer from paper to electronic records had not always been completed correctly.

There were enough staff to keep people safe and relevant checks had been made before staff commenced employment.

We saw people's medicines were administered, recorded and stored correctly.

Is the service effective?

Requires Improvement

The service was not always effective.

We found that staff were supported through regular supervision and appraisal, and also had access to ongoing training.

People were asked their consent prior to any care intervention and the registered manager was complying with the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

People did have some support with eating and drinking but we did highlight that alternative equipment could be used to promote people's dignity when aiding their nutrition and hydration.

We saw the service was pro-active in securing the help of other professionals where needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not all supported when required. We observed some staff were slow to respond to a call bell on one occasion.

We saw some staff were aware of privacy issues but others were not.

Some staff did not respond to people's wishes when expressed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw that people were engaged in some positive activity which the activity co-ordinator instigated

We saw little evidence of spontaneous interaction with people, especially during the morning.

Summary of findings

Not all staff had access to the electronic records directly and were reliant on nursing staff sharing information. The continued use of a paper system meant the risk of errors and omissions was high.

Is the service well-led?

Requires Improvement 

The service was not always well led.

People and staff told us they liked the home and found it a nice place to live and work.

We found the registered manager had taken our previous concerns seriously and acted upon them effectively. They were responsive to situations and provided an effective role model for staff.

However, we highlighted concerns around the two record systems (paper and electronic) that had not been identified by management. This meant they did not have robust audit systems to ensure all aspects of this area were working well.

Newsome Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 June 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, one specialist advisor whose background was nursing and one Expert by Experience whose experience was in older people's services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this in conjunction with notifications we had received from the service and feedback from the local authority commissioning team.

We spoke with 14 people who lived at the home and two relatives. We also interviewed nine staff including three carers, one nurse, the chef and kitchen assistant, the maintenance staff member, the registered manager and the area manager.

We looked at 14 care records, 10 of which specifically to identify evidence of compliance with the Mental Capacity Act 2005 and other legal frameworks. We also saw other documentation showing how the home assessed quality of their care including accidents and incidents, maintenance logs and action plans stemming from visits by external teams such as infection control and contract monitoring.

Requires Improvement

Is the service safe?

Our findings

We asked people living in the home if they felt safe. One person told us "I feel safe. The staff make me feel safe". Another person told us they felt "safe and confident with the staff, they know what they are doing".

We spoke with staff about their understanding of safeguarding. One explained that a possible safeguarding situation may be when the wrong piece of equipment is used to move someone. They were aware of where to report such concerns. Another also emphasised the importance of following correct moving and handling techniques. They said they had never had any concerns about any of their colleagues with regards to poor practice but would know how to follow whistleblowing procedures if necessary.

However, we observed two members of staff sitting at the dining table with people living in the home while a cookery based activity was underway. One person in a wheelchair was accosted by a fellow person living in the home and a verbal altercation ensued. The staff members allowed the disagreement to continue and did not make any effort to de-escalate the situation, until the situation reached crisis point and the person sat in the wheelchair threw a hat at the other individual. It was then that both staff intervened by moving the person in the wheelchair out of the dining room and into the lounge, assisting them into an armchair. Neither member of staff asked either service user how they were following the altercation and we did not see any attempt made to report this incident to the nurse in charge. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safeguarding service users from abuse and improper treatment as people were not being supported either during or after a situation that led to distress.

The registered manager demonstrated a thorough understanding of the importance of reporting safeguarding concerns. Prior to our inspection we looked at the notifications outlining both the incident and the subsequent investigation and resulting actions. These were always detailed, timely and appropriate.

We completed a tour of the premises as part of our inspection. We inspected five people's bedrooms, bath and shower rooms and various communal living spaces. All radiators in the home were covered, or were of a cool panel design, to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions.

We saw upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows.

We found all floor coverings were appropriate to the environment in which they were used. All floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed.

We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date.

However, we found that the home struggled from a lack of storage space. A toilet next to someone's room was inappropriately used for storing mobility equipment and was totally inaccessible. It was also unlocked which could have posed a hazard. Another area causing concern was the dining room as this had equipment lined up in front of the fireplace. Although we saw some of this in use during the day, not all of it was used and it made the dining room looked cluttered and there was limited space. We discussed this lack of appropriate storage with the provider and asked them to consider a better solution.

We saw that each person had clear, concise risk assessments in place which were individualised to their needs. Each risk assessment had an identified risk and an intended outcome, in addition to how the staff could minimise the risk to the person. The risk assessments were linked to each care plan. These risk assessments were completed fully and were informative demonstrating that staff understood the needs of the people they were caring for. The level of risk was not always identified in some areas meaning that at a glance it was not possible to see whether people were deemed low, medium or high risk, specifically in terms of mobility. As a result, in order for staff to identify and interpret the level of risk, they had to access the full risk assessment.

Whilst most risk assessments were robust we found evidence when the risk assessment and our findings conflicted. For instance we saw one person had a mental health risk assessment to gauge the person's risk of harm to others or to themselves. The risk assessment indicated they had not shown or expressed thoughts about harming

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others nor had they a history of doing so. In the accident and untoward occurrence section of the care plan we found a statement indicating the person had caused bodily harm to staff and had made an attempt to strangle a member of staff. We brought this to the attention of the manager who said they would remedy the inconsistency and ensure the risk assessment accurately reflected the person's needs.

The provider was in the process of transferring people's care records from paper over to electronic care records. On the electronic system, there was provision for staff to document any accidents or incidents that a service user experienced.

The registered manager was aware that some accidents may have been logged incorrectly and that some staff were still using the paper accident and incident reporting forms. Upon reviewing the accident and incident reporting section of the care plans, we noticed that there were some incidents that had been logged incorrectly. For example one person had a documented episode of a "painful wrist cause unknown" that had been logged on the electronic system as a burn.

The registered manager told us they reviewed all accidents and incidents at the home to identify trends and take appropriate action to prevent a similar incident occurring in the future, therefore it was important for all to be recorded accurately. This was evident in the management meeting minutes.

We asked people living in the home whether there were enough staff. One person told us "Most of the time there is enough staff around but sometimes there is not ". They did not give any more detail. A relative said "if you want someone you can find them. Sometimes there are not enough staff in the lounge".

We spoke with staff about how staffing was organised. One member of staff said "there is a nurse on duty all the time and agency staff are used occasionally. They tend to be the same people. Sickness is low and team members will challenge if 'someone tries to swing the lead'. Another staff member told us "it's usually regular staff, only if there is illness do we have agency staff. We are asked first if we can pick up an extra shift".

We asked the registered manager how the staffing ratio on the unit for people living with dementia was determined. They informed us that there were two members of staff assigned to assist the two people living in this part of the home during the morning. Once the activities co-ordinator had arrived, these individuals were then engaged in an activity while the staff members assisted people living in the other area of the home. The registered manager told us there were two staff on duty overnight in the unit for people living with dementia.

The registered manager also explained they had been using the same agency nurse for some time but they had recently managed to recruit to this position. They told us no one was receiving one to one care on the day of our inspection. We felt that there were enough staff on duty as they were visible and assisting people throughout the day.

We found there were effective recruitment and selection processes in place. We took a random sample of five staff files. Records showed robust recruitment procedures were followed and relevant checks carried out before an offer of employment was made. These included full employment history, proof of identity and two references. Disclosure and Barring Service certificates were received prior to the commencement of employment. Checks on registered nurses with the Nursing and Midwifery Council were completed prior to employment commencing and the service had a robust method of checking periodic re-registration.

We saw all applicants completed an application form. They were then interviewed by the manager before being offered employment. Appropriate checks were undertaken before staff began working with people who use the service. All employment commenced with a comprehensive induction programme and its outcomes were retained in the staff file.

Medicines were administered to people by trained nursing staff. We were told people were assessed as to their capability to self-medicate. Whilst no people had been found capable of self-medication the process demonstrated the provider was attempting to maximise people's independence.

We spoke with one person living in the home who told us "The staff have explained to me about my medication. I get my medication on time".

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and all medicines accounted for. Most

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medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

Our scrutiny of the MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given.

We looked at prescription sheets and care records to ascertain the frequency of use of PRN antipsychotic medication to control periods of behaviour that challenged the service or others. In discussion with nursing staff and the scrutiny of the MAR sheets we were assured that non-pharmacological interventions were the preferred method of supporting people.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs accurately recorded and accounted for.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. We saw the provider conducted regular audits of medicines with the intention of ensuring medicines were safely administered and accurately accounted for.

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Is the service effective?

Our findings

We asked people if they felt staff were experienced. One person told us "The staff seem to know what they are doing".

Staff we spoke with told us "staff get a lot of support. The registered manager asked if I had any questions. I felt really comfortable". They went on to say they received supervision every three months and had recently had an appraisal which looked at their performance. The staff member said "I was asked how I feel and if I need support with anything, and never be afraid to ask for support if I feel I need it".

Another member of staff said they had found the job difficult initially as it was very different from their previous role. However, they had been supported during their induction and subsequently with training. They had also had supervision and an appraisal in March 2015.

During induction to the service, we saw staff received training that complied with the Skills for Care Common Induction Standards to ensure they were given the skills and knowledge to enable them to meet the needs of the people using the service. We looked at the training records of the three most recently recruited members of staff. Records showed they had successfully completed their mandatory induction training.

We asked the registered manager how staff were supported to fulfil their role and they said in addition to individual supervision the registered manager attended morning handovers regularly, partly for their own knowledge of what was happening but also to support staff and be a source of information. They also told us they had group supervision sessions where they discussed a particular topic such as infection control. We saw evidence that supervisions were happening as we had been advised. During our inspection in February 2015 we found the provider was not meeting the required standard with regard to staff supervisions and appraisals. This inspection showed corrective action had been taken by the provider and the previous regulatory breaches had been remedied.

We looked at a sample of staff training records and found staff had access to a programme of training. Mandatory training was provided on a number of topics such as safeguarding vulnerable adults, manual handling, food hygiene, first aid and fire safety. Additional training was provided on specialist topics such as dementia. We found the training plan was being adhered to across all staff groups employed in the home.

We asked people if they were asked before receiving any assistance with personal care or other support. One person told us "They ask me if I want to do anything and if I say no they respect my wishes". Another told us "I have the freedom to do what I want". A further person said "I can make my own choices about everything". Another person said "I make my own decisions and the staff help me to keep me independent". This shows the service was acting in accordance with principles of the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We were told three people using the service were subject to an authorised Deprivation of Liberty Safeguard and a further four applications had recently been made. Our scrutiny of people's care records demonstrated all relevant documentation was securely and clearly filed, and appropriate input from the multidisciplinary team and external agencies had been sought and evidenced.

We saw on one occasion the best interest assessor had recommended conditions be attached to the authorisation. We saw bespoke care plans had been constructed to ensure the conditions would be acted upon and be subject to regular review.

We spoke with the registered manager to gauge their understanding of current legislation regarding the Mental Capacity Act 2005. Their answers demonstrated a thorough understanding of the law and how it had to be applied in practice. Staff we spoke with also had understanding of the importance of seeking every possible means of gaining someone's consent and we were told about one person who used flashcards to help them make decisions.

Our discussions with the registered manager also identified other people in the home may be being subject to a deprivation of their liberty. We saw from care plans some people had been assessed to determine their mental

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capacity. Care plans showed people had been found not able of making daily living choices, or not being able to hold information long enough to make a decision. We saw evidence that the registered manager was in the process of submitting the required applications.

We spent time looking at care plans and discovered difficulties in always accessing the correct section. In one record the mental capacity assessment appeared to be a blanket statement that 'the person lacked capacity due to their dementia'. A different one said the person lacked capacity due to their stroke. We asked the senior care assistant on duty if they could tell us why this person was deemed to lack capacity and they said "well, they can't speak after their stroke so we can't tell if they understand what we are saying or asking them to do". We asked if they used picture cards or other ways to communicate with this person and they said they did not. We met this person during the afternoon of the inspection, and although they were unable to speak, they were able to answer questions by use of hand gestures, facial expressions and sounds. This means that the service had not accurately recorded the detail for the capacity assessment as the person was able to make their wishes known.

Upon further investigation we found that the detailed assessments were not linked onto the system to the overview ones, hence leading to this misinterpretation. There was no evident link from one assessment to the other, making them seem as though they were conducted independently from one another when in fact they were one and the same. This was discussed with the registered manager on the day of the inspection who stated they would ensure the assessments were linked in future. This also meant that due to the difficulties we had in understanding the records this was likely to happen with staff. Given that the care staff had not had access or training for the use of electronic records, this needed immediate action which we advised the provider of. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not were not always accurate or available to all staff who needed to access them.

We saw a record of a Court of Protection order issued to manage the affairs of a person who had lost capacity to make their own decisions, where they had not planned ahead by making a Lasting Power of Attorney. A Deputy, in the form of a close relative, had been appointed to assure the person's health and welfare. We spoke with senior staff who were fully aware of the order and how it needed to be applied. This demonstrated the staff were aware of important legal matters that may affect the organisation and planning of people's care.

We saw the provider's restraint policy promoted a restraint free approach to care which recognised the use of restraint only after exhausting all reasonable alternative management options. We looked at a sample of care plans for people who had bed-rails in place. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw, where relevant, families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

However, whilst issues of possible restraint had been effectively dealt with regard to bed-rails, other aspects of physical restraint management had not. We noted from the accident and incidents file an entry made five days before our inspection. It recorded '[staff name 1] had to physically remove [name of person] hands from pulling on [name staff 2] uniform and trying to strangle her'. A discussion with the registered manager indicated staff had received no training in how to use appropriate techniques to control adverse and threatening behaviour which may be harmful to others. This omission left both people receiving care and staff vulnerable to the effects of unlawful restraint. The registered manager assured us the issue would be immediately dealt with.

We could not see in the electronic care records we reviewed, any evidence that the person living in the home had consented to care and treatment, the sharing of information or the use of photography. The registered manager told us that each person or their next of kin had signed a consent form but that these were held within the paper records. We saw evidence of this.

We asked people their views of the food in the home. One told us "We have enough fruit and vegetables, the food is good and nourishing". Another said "There is plenty to drink all day; they come round with drinks". A further person told us "The food is always hot and tasty and we can have more if we want to, but I'm always satisfied". We saw extensive menu plans and found them to responsive to people's preferences.

Requires Improvement

Is the service effective?

One person who had had a stroke was positioned on their side in their bed when we observed them eating. We asked them why this was the case and they told us 'because the tray they were using was not high enough'. They felt "a proper table that goes across the bed would be much better". We were advised by the registered manager that this person often moved onto their side through their own choice as they felt more comfortable. They were supported to use a wheelchair but found sitting uncomfortable. The registered manager agreed to look at alternative support for this person when eating.

We observed people in their rooms being supported with eating and actively encouraged in some instances.

Another person told us "I do not like drinking out of these plastic feeder cups. If I could sit up properly I could have a cup and saucer that would be good". The person went on to say 'they felt like a young child'. We felt that perhaps alternative equipment could be researched that helped promote people's dignity.

We saw at lunchtime only six people were sitting around the dining table as this was all it could accommodate at one sitting. Another fourteen were in the lounge eating their dinner from tables positioned at the side of their armchairs. We saw this led to bad posture for some people. We observed one person slumped to the side of their chair. They had some difficulty cutting their food and they had no plate guards to limit the movement of food on the plate. Neither did there appear to be any non- slip mats on the tables to ensure the plate remained steadfast. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 meeting nutritional and hydration needs as people did not always have the appropriate equipment to enable them to eat or drink safely.

We saw that some care records were completed with specific care plans in place relating to nutrition and hydration. We looked at a care plan for someone who was fed via a PEG (Percutaneous Endoscopic Gastroscopy) tube. This is used to assist someone who has swallowing difficulties following assessment by Speech and Language Therapists (SALT) and dieticians. Due to the PEG tube being placed directly into the stomach, people can receive some or all of their nutrition and fluids without having to attempt to swallow.

Staff had formulated a care plan detailing the person had a PEG tube in place, and identified potential problems that could occur and what action they would take should any of these problems arise such as "if the tube falls out, staff are to insert a urinary catheter and inflate the balloon, then send (the person) to A&E". The staff had identified that the Malnutrition Universal Screening Tool (MUST) should be used but did not detail within the care plan the significance of this tool. The care plan did not state what the person's regime was, where to order the equipment and feeds, or the details of the specialist nurse to contact in an emergency. We were later advised by the registered manager that this information was in the person's own room but this was not referenced in the records we looked at.

The second person's care plan we reviewed stated the person's MUST score was 0 meaning they were not at risk of malnutrition at this time and had not suffered weight loss. The person's weight had been recorded as requested by the dietician to be checked on a weekly basis. Over the past three months, this person had lost 18.68% of their body weight meaning they should have had a significant MUST score of 3 or above. There is therefore a need for staff to receive further training in this area as this was not identified. Although the person had recently begun to gain weight this needed to be consistent and sustained for the risks to be removed, and therefore ongoing monitoring was required.

We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, community nurses, specialist nurses in diabetes, speech and language therapists, dieticians and dentists. The home had a positive working relationship with their registered GP who visited the home on a monthly basis and reviewed each person.

Requires Improvement

Is the service caring?

Our findings

One person told us "The staff are nice and kind to me". Another said "The staff know me as a person, they know when I am down and they sit and talk to me to find out what is wrong". A further person said "The staff are very kind and thoughtful, if they want to do something they always ask if I mind". We were told "The staff are very friendly and caring, very much so". This attitude was extended to relatives as well as one told us "The staff are lovely. They are respectful towards my husband and me".

We saw some interactions which were positive between the staff and people living in the home. Staff appeared to be kind and friendly towards each person and in the afternoon spent time in the lounge chatting to them. We found this tended to be with people who were able to communicate easily. However, we also saw one person who could not communicate as easily due to their dementia and there was little interaction from staff with them.

We observed that on occasion, call bells could be ringing for some time before being answered. We overheard staff say on at least two occasions, 'Where is it? The other side?' as if they were not aware of the layout of the home. In the afternoon the call bell rang once for four minutes while we observed three staff talking in the reception area. They then went to answer it together. This showed that not all staff were ensuring people's needs were met promptly risking their dignity.

We saw staff knocked on doors before they entered people's bedrooms which indicated that staff were respectful of people's privacy. However, in some cases the member of staff knocked and immediately walked in without waiting for the person to answer and allow them entry. One person told us "The only privacy is in my room" which showed that people were encouraged to have their personal space. We asked staff how they ensured they respected someone's privacy and were told "we make sure the door is closed and put screens around if we need to help someone".

However, in the morning as we walked past one room the person asked for help to go to the toilet. We asked a member of staff to assist and we heard them say under their breath "I bet they don't really need it as they've just been". We then observed that while the person was being assisted onto the commode their room door was left open. This compromised their dignity and showed a lack of respect for the individual concerned.

While on the first floor we saw that although the medicines trolley was locked it was positioned just opposite the lift and people's records were on full view with no staff member visible. There were also empty medicine containers left on the top. The service needs to be aware of the importance of protecting people's personal information as while we were in this area two visitors came in via the lift. We also found that positional charts were on the walls outside people's rooms, again compromising personal information security.

We spent time in the lounge and dining room on the ground floor arriving approximately at 9.30am. There were two people who sat at the dining table in a wheelchair, eating their breakfast. We asked a member of staff why these people were not assisted to sit in a dining chair and they replied "they are going to the hairdresser to have their hair done very shortly. We will sit them both in a chair when they get back from the hairdresser".

We were still in the dining room when both people returned from the hairdresser. They were not asked if they were comfortable or offered the chance by staff to sit in an armchair. They were positioned once again at the dining table in their wheelchair. One person asked to go to their room at approximately 10.40am and the carer replied "have your lunch first, it is dinner time soon". Lunch was not served until 12.45pm approximately therefore this person was left to sit in their wheelchair and their wish to return to their room was not respected.

We heard this person ask to go to their room at 2.15pm and staff member who responded said "Do you want a chocolate milkshake?" The staff member also offered biscuit and fruit as well which the person refused. This person was eventually assisted to their bedroom at 3pm meaning they had been in their wheelchair for at least five and a half hours, with no attempts made by staff to make them comfortable in an armchair or assist them back to their bedroom as they had requested. We did not see this person offered any pressure area care or assistance to visit the bathroom during this time.

Another person asked to go to their room at 2.40pm and they were not moved until 3.40pm. This was partly due to

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Is the service caring?

an absence of staff in the lounge for some of this period. The observations detailed above are all breaches of Regulation 10 Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 as people's needs were not always met in a timely manner and they did not always have their privacy respected.

We were told that one person had been appointed with an Independent Mental Capacity Advocate (IMCA). While the person was not able to speak to us about the advocacy it was clear the appointment was relevant. The person had no-one who could be appropriately consulted when making a decision and being subject to DoLS they did not have the capacity to make that decision alone.

We scrutinised a random sample of six of the nineteen care plans which recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital or transferred to another care home.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they felt the service met their needs. One person told us "The staff listen and act upon it". Another said "I get involved in all the activities and I knit".

During the morning of the inspection, we observed activities in the main lounge. We saw that staff did not spend meaningful time in the lounge with people living in the home during the morning, though staff did regularly pass through the area. We saw that staff appeared to be rushed and hurried and the interactions we witnessed during the course of the morning appeared to be very much task and routine led. This did improve, however, at approximately 11am when the activities co-ordinator arrived and successfully engaged as many people as possible in a cooking activity. The visibility of staff within this area during the afternoon was much improved and staff did appear to spend more time with the service users and interactions appeared to be more meaningful.

We observed some excellent interaction in the unit for people living with dementia. We found the activities co-ordinator was setting up for 'Italian day' and encouraging the people to engage in helping to decorate the lounge accordingly with flags and balloons. We saw one person was playing 'keepy-uppy' with a balloon engaging in an activity which promoted co-ordination and balance. People were talking about Italy and other countries they had visited. Later people were supported across to the main lounge where they helped make tiramisu.

Staff told us they also had visits from the local church for people who wished to participate, and games were played such as 'play your cards right' and jigsaws. One member of staff told us that time had been spent with people recently looking at old photographs of the area. We also saw that people were supported to go to the hairdressers, which was on site. In one person's situation this was by encouraging them to walk at their own pace providing support from a wheelchair when they needed to sit down.

The outcome of risk assessments at the point of admission to the service were used as the foundation to create a safe care plan covering, mobilization, toileting, nutrition, communications, mood, night care and personal hygiene. We saw staff daily recorded outcomes of the care plan and took steps to modify the plan in light of people's experiences or changing health care needs.

Care plans recorded what the person could do for themselves and identified areas where the person required support.

The provider was in the process of transferring all the information from paper records over to an electronic care planning system. We discovered through talking to staff that on the day of inspection only the nursing staff had access to these electronic records and that care staff were still using paper systems. The registered manager was advised to take immediate action to ensure a uniform way of recording was implemented to reduce the risk of errors and omissions occurring.

One person told us "I have not been involved in a discussion about my care needs". The registered manager said the records relating to person and relative involvement were held on paper. We saw evidence of this. However, in the new electronic reporting system, there was no detailed evidence that we could see which demonstrated how people were involved in their care. There was a section in each person's record for staff to document the likes and dislikes of each individual. However, in all cases this was blank and not completed.

We looked at the care records of a person with pressure ulcers as a result of self neglect prior to admission to the home. This person's care plan was extremely detailed. It was clear that the individual had been referred to and seen by Tissue Viability Nurse Specialists. These specialists ensure that healing of wounds is promoted and the risk of infection is reduced. We saw that the wound care plan was evaluated monthly. It did not state in the care plan which dressings were used or where. Appropriate pressure relieving equipment was in place for this person. However, the daily care record where carers were documenting the frequency of repositioning this person and the condition of their skin was not completed. We were not able to assess their skin integrity. This was also the case when we reviewed the same record for the other three people living in the home. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as care records were not being kept appropriately.

There were comprehensive records in relation to managing someone's diabetes as they required regular blood tests and responsive action. Despite the person sometimes refusing these necessary tests, there was evidence that staff had attempted successfully at various points throughout

Requires Improvement

Is the service responsive?

the day to check these levels. There was good evidence of involvement of specialist diabetes nurses and GP involvement with clear instructions documented on how to manage episodes where the person experienced higher blood glucose levels than is usually acceptable. It was clear that staff were following evidence -based rationale and were in regular communication with the person's medical team and family regarding this. There needed to be some clarity of definition around 'hypoglycaemia or hyperglycaemia' in the care plan, as is suggested these states had the same cause which is incorrect.

We reviewed the daily recording chart of one person who received all food and fluids via a PEG tube. The fluid records were incomplete and had not been completed for several days between the hours of midnight and 06am and 9am to 3pm. Fluid balance was not completed at the end of the 24 hour period meaning that it was unclear whether the person was at risk of dehydration. The registered manager agreed to take immediate action after we pointed this out to them. This is a further breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as care records were not being kept in a timely manner.

We asked people if they knew how to make a complaint. "If I had to raise a concern I would tell the manager, but I never have had to raise one I have no complaints at all. I like living here". Another person told us "I have no concerns but if I did, I would make a complaint to the manager. I know them; they are very approachable".

We looked at the complaints register. Since our last inspection four complaints had been made. We saw the complaints had been quickly investigated with a response to the complainant within 28 days. We saw the response was commonly by letter but on appropriate occasions with a face-to-face meeting. We did not detect any common themes to the complaints which may indicate issues were not being resolved. We saw the outcome of any internal investigation was filed along with the complaint.

One person said "We have had two or three questionnaires since being in here" as the provider sought the views of people living in the home. We were shown the results of the latest survey sent in February 2015 which included feedback around 'friendly and professional staff' and issues around laundry.

Requires Improvement

Is the service well-led?

Our findings

"I would describe this home as homely with a nice atmosphere" one person told us. Another said "I like living here. I would not want to live anywhere else, it's nice and peaceful, a happy and relaxed atmosphere".

Staff also said they were happy working in the home. One told us "I enjoy working here. The manager is very approachable". We were also told the regional manager visited often so staff felt able to approach them as well. Another member of staff said "I get a lot support from colleagues. I can talk to the manager with any queries or problems". Another said "It's a good team. We're never left without a nurse".

Staff told us they liked the keyworker system because this meant they got to know some people really well. However, when we asked who was involved in reviewing care plans we were told that it was nursing staff. We were told that nurses also led the handover sessions. These were spoken sessions but both carers and nurses were expected to make notes so they had full information before going on shift. We did see outline notes from the daily handover record. These were more detailed where required thus ensuring that people with changing needs were identified.

At our previous inspection we found there was a breach of regulations regarding staff supervision and appraisals. This had been rectified at this inspection.

We spoke with the regional manager and registered manager about the lack of access by care staff to the electronic records. They explained they were waiting for the supply of more net books. However, we were concerned that the service was trying to run with two separate systems and the potential for error or omissions was significantly heightened because of this. We also stressed that training needed to be given as well as some staff indicated their lack of knowledge around electronic systems. The registered provider agreed at our feedback session that this would be remedied by the end of June.

We asked the registered manager about staff meeting minutes as the latest we could find were dated 15 April 2014. They did admit that these had these had not been frequent. However, they did explain that they attended the morning handovers, usually three or four times a week. This was an opportunity for staff to speak to them to raise any concerns. They also explained they conducted group supervision following situations such as the recent infection control visit. We saw written records of this to staff. Another example of this was identifying poor record keeping with regard to positional charts for people.

We saw that the registered manager had completed an unannounced visit at 3.30am on 20 May 2015. They had checked staffing and found no concerns on their visit. This shows that the service was keen to ensure quality was being monitored at all times of day.

We found records of monthly management meetings which detailed comprehensive staff management in terms of ensuring completion of supervisions and appraisals, and also performance management issues where necessary. There was also evidence of audit analysis, for example determining trends for accidents and incidents.

We saw records from a recent visit by the Infection Control team with specific action points which were being addressed. Areas included lack of regular pressure care, clutter in communal areas, access to hand gel and ordering of specific slings for people's own use. The service was reminded of the need to consider better storage solutions.

We asked the registered manager what they felt their key achievements were. They told us that families gave positive feedback about the care received and we saw this in thank you notes displayed in the reception area. They also said they focused on building positive relationships with all they worked with and again this was reflected in feedback we had seen from professionals when seeking out information prior to our inspection. We saw that the service was timely in requesting help from other professionals where required and knew where to refer for more specialist help.

We also saw copies of minutes of relatives and family meetings. This had low attendance but was the first in some time so the registered provider was trying to engage with people using the service more. This was confirmed by one person who told us "I have been to one residents' meeting but they don't have them very often".

We saw evidence through supervision notes that the registered manager led by example. They gave clear instructions of the need for certain actions and the implications of not doing something a particular way, for example in the recording of care records. This was

Requires Improvement

Is the service well-led?

supported by group supervision and disciplinary action where required. They said they would help out with people's care if needed in situations and this was verified by staff.

During the afternoon, we observed two members of staff speaking in a foreign language to each other. This was not appropriate behaviour as they were on duty and supposed to be supporting people living in the home rather than having a private conversation that others could not understand. When they saw us approaching them they both stopped speaking. We encountered this on a second occasion, involving the same two members of staff later on in the afternoon. We discussed this incident with the registered manager who stated that they were aware of this issue with these two particular members of staff and had discussed it before. They assured us they would be taking further action in relation to the conduct of the two staff.

The registered manager was reporting to the Commission notifications as required under legislation in relation to safeguarding and serious injury. We saw an authorisation for DoLS had been received five days before our inspection. The manager had informed the CQC of the authorisation and this was also the case with regards to safeguarding incidents.

We spoke to the maintenance staff member who said" If I want to do a job they always give me enough money to carry out the task, the provider does not cut corners".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy was not always ensured when receiving support with personal care tasks and we observed that people's wishes were sometimes ignored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were not pro-active in diverting people when we observed a verbal altercation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We observed inappropriate or lack of suitable equipment to assist people with eating and drinking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not always accurate or complete meaning that people could have been placed at risk of harm. Neither were they accessible by all staff on the day of our inspection as some were electronic and only accessible by the nursing staff.