Care Quality Commission

Abbey Healthcare (Kendal) Limited

Heron Hill Care Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place over two days on 21 and 22 October 2014. During our previous inspection visits on 22 July, 9 August and 10 September 2014 we found the service was not meeting all the regulations we looked at. This was because the registered provider did not have appropriate arrangements in place to manage and monitor medicines safely, was not ensuring that the premises were being well maintained and that premises and equipment were kept clean and hygienic to reduce the risk of infection.

We took enforcement action and issued three warning notices to the provider that required them to make immediate improvements in relation to the way medicines were managed and monitored. The warning notices also required them to make improvements to the environment, equipment and infection control to protect people living at the home.

The registered provider wrote to us and gave us an action plan saying how and by what date they intended to improve the premises, infection control and the way

Summary of findings

medicines were managed. The registered provider also gave us a voluntary undertaking to take no further admissions whilst they addressed the breaches. At this inspection on 21 and 22 October 2014 we found that the registered provider had made the improvements needed to meet the requirements of the warning notices and compliance actions from the previous visits. However at this inspection we found that there were others breaches of regulations that had an impact on people living in the home.

Heron Hill Care Home provides accommodation and nursing care for up to 86 people. The home is on three floors and has four separate units each with separate dining and communal areas. All bedrooms are single occupancy and have ensuite facilities. The service provides support to adults who have a physical disability, mental health needs, behaviour support needs, dementia and complex nursing needs.

The service had a registered manager in post. 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 and associated Regulations about how the service is run.

We found that there were adequate numbers of staff to provide support to people to meet basic care needs but the registered provider had not always made sure there was the right mixture of staff skills and experience on all shifts to meet assessed needs and behaviours. We also found that training and staff support was not being well monitored or recorded so people could be sure all staff had the right skills and experience to support them.

We found that records of what staff training had taken place and staff supervision were not up to date. We saw that staff working with people whose behaviour may challenge the service were not being enabled to access accredited training relevant to their workplace and role. This meant that people could not be sure that staff always had the right training to carry out their roles effectively.

There were limited organised activities provision available to people. We found that reductions in the activities staff meant that people were not regularly being given the opportunity to have support to follow their own interests and to take part in organised activities with others. This could affect their social inclusion.

The systems used to assess the quality of the service had not identified all the issues that we found during the inspection. Whilst we found that some aspects of the quality monitoring processes were being done well others, such as monitoring staff training.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to making sure staff always had the right skills, competencies and knowledge to meet the needs of people who used the service. The registered provider had not made sure that all staff in the home had received induction training, appropriate training for their roles or regular supervision and appraisal to monitor their performance. We also found that people were not being protected against the risk of unsafe care because the registered provider had not made sure that all aspects of service provision were being regularly monitored for effectiveness. You can see what action we told the provider to take at the back of the full version of this report.

We found that people living at Heron Hill Care Home were able to see their friends and families as they wanted. There were no restrictions on when people could visit them. We could see that people made day to day choices about their lives in the home and were able to follow their own faiths. People living there and visiting relatives told us that staff were polite and caring and "Worked very hard".

The premises and equipment were being well maintained for the people living there. People's needs had been assessed and care plans developed. There were suitable hoists and moving aids in use in the home to assist with the different mobility needs of people living there.

Staff had liaised with other healthcare professionals to make sure specialist advice was available to people for the care and treatment they needed. Medicines were being administered and recorded appropriately and were being kept safely.

Care records contained information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had

Summary of findings

discussed with people if they wished to be resuscitated. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The home had effective systems when new staff were recruited and all staff had appropriate security checks before starting work.

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

Since our inspections on 22 July, 9 August and 10 September 2014 there had been significant improvement in the maintenance of the premises, the cleanliness and hygiene and the safe management of medications. This meant these aspects of the service were now safe and being managed.

However, aspects of this service were not safe. We found that staff skill and gender mixes were not being fully considered when staffing units in the home to make sure people's needs were well understood and met. There was very little flexibility to respond to any changing circumstances in the service to cover sickness, absences, vacancies and emergencies.

Staff had been recruited safely with all relevant security checks in place. Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

There were suitable hoists and moving aids in use in the home to assist with the different mobility needs of people living there.

Is the service effective?

Requires Improvement

The service was not effective. Training records we examined were not up to date and had not been updated to show what training, including mandatory and induction training staff had done, what updates were due and what staff were still required to undertake particular training.

Staff supervision was not being consistently offered to all staff working in the home There was no verifiable evidence of when new staff had received induction training and when they had been assessed as competent by their manager.

People were supported to have sufficient food and drink. Where the home had concerns about a person's nutrition they involved appropriate professionals to help make sure people received the correct diet.

Where people had complex health care needs, appropriate specialist health care services were included in planning and providing their care.

People's rights were protected because the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

Is the service caring?

Good

This service was caring. People were treated with respect and their independence, privacy and dignity were protected and promoted. People were able to see personal and professional visitors in private.

We saw that staff engaged positively with people and were friendly and polite.

Summary of findings

People and their families had been included in making decisions about their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive to people's needs. Some aspects of care planning to meet people's needs were lacking in detailed guidance for staff.

There had been a reduction in the number of dedicated activities staff working in the home. This could result in people not being given the opportunity to follow their interests and be supported to take part in social activities and interaction with others. This could mean they did not receive the support they needed to avoid social isolation.

The management and staff at the home worked with other agencies and services to make sure people received the care they needed.

People were supported to maintain relationships with friends and relatives. Family members spoken with confirmed they could visit whenever they wished.

There was a system in place to receive and handle complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not well-led. Although there were systems to assess the

quality of the service provided in the home we found that some aspects of quality assurance were not being used effectively. Staff training and development had not been effectively monitored to make sure that all staff had received induction training, on going training and supervision. This meant that people living in the home could not be certain that the staff caring for them had the right skills and training for their roles.

We saw that care plan audits had not always picked up conflicting information in care plans. This meant that staff may not have accurate information about people's needs to work from.

Other aspects of the quality monitoring system had been greatly improved such as medication handling, hygiene, infection control audits and premises and equipment audits.

There was a registered manager employed in post and they had just returned from a period of sick leave. During that period the deputy manager also had left. This meant there had been a period of time when leadership in the home had not been consistent and may have led to a a lack of leadership for staff.

Heron Hill Care 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 was an unannounced inspection that took place on 21 and 22 October 2014 and was carried out by two adult social care inspectors and a pharmacist inspector. At our inspection on 21 October we focused on speaking with people who lived in the home and their visitors, speaking with staff and observing how people were cared for. The inspectors returned to the home on 22 October 2014 to gather further evidence around some areas and to look at staff records and records related to the running of the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection visit we gathered information from a number of sources and reviewed the information we held about the service. We looked at the information received about the service and from concerns and complaints that had been raised with us about the service. We contacted local commissioners of the service and two health and social care professionals who were familiar with this home to ask their opinions about the care and support provided.

We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards.

Before the inspection, we asked the provider to complete 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. They did not return a PIR but contacted us so that we were aware of the circumstances around this. We took this into account when we made the judgements in this report.

During the visit we spoke in private to nine people who lived in Heron Hill Care Home and other people within communal areas as we went around the home. We were able to speak with five people who visited the home on the day of the inspection. We spoke with 13 staff during the inspection. This included nursing staff and care staff, domestic, maintenance and activity staff and spent time with the registered manager.

We looked at the care and support plans for 14 of the people who lived in Heron Hill to help us track how their care was being planned and delivered. We examined staff rosters, the training plan, staff recruitment files and the quality monitoring and assurance systems in use.

The pharmacy inspector carried out a detailed inspection of medicine management, storage, administration and disposal. As part of the inspection we also looked at records, medicines and care plans relating to the use of medicines.

Requires Improvement

Is the service safe?

Our findings

People we spoke with who lived there told us they felt safe living there. We were told, "I feel safe enough here, I've got my alarm bell if I need it". Another person said, "I'm safe here and my family can come and go and see I am OK and staff pop in from time to time". One person, who had not been living in the home long, told us, "It's going OK. It's a comfort to know there is someone about if I need them".

One person we spoke with who lived there told us that "Some days there are more staff than others, sometimes they are run off their feet and other times they can have time for a chat". Another person told us "Some staff I know well but others I don't, some don't seem to stay long". We were also told by a person living there, "They (staff) can be really pushed, I won't see them now until lunch but I can ring my alarm and they come. They have never not come but it might not be straight away".

We asked relatives visiting the home about how the home was staffed. We were told "They need more staff some days, there have been big changes in the staff with agency staff. I think some of them lack an understanding of dementia". Another relative told us, "The staff are kind and caring enough but cut corners". We were also told "They need more regular staff".

We found that staff levels fluctuated and staff moved to work on different units with people they were not familiar with. Staff told us that they moved around units to help maintain numbers as needed and were working additional shifts to try to cover. Staff did tell us that "things" were "Getting better with the agency staff" and that they would "Not be able to cope without them". We were told that that at times staff felt they had been "Stretched too thin" and there had been times when they had not been able to provide one to one support as they would have liked. However we were also told that "There are a lot of agency but I don't think that has affected care". Also "Staffing levels are better now, morale is much better" and also "It was really bad but I enjoy coming to work more now".

The comments made to us indicated that although the management had put staffing contingency plans to maintain the staff establishment the staffing pressures may not be safely sustainable in the long term.

We looked at the staff files for eight people, four of whom had recently started to work. We found that the appropriate checks had been completed before they had started work. References had been obtained and proof of identity.

The staff recruitment files showed that a Disclosure and Barring Service (DBS) check had also been completed before they had started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helped to make sure that the right people were employed for caring work by the service.

We spoke with staff about keeping people safe and what they would do if they witnessed bad practice. They said that they would challenge their colleagues if they observed any poor practice and would report their concerns to a senior person in the home. There was evidence that we had received to indicate that staff had brought such things to the attention of management and action had been taken, including disciplinary action. They told us they knew about the whistleblowing procedure and we saw that information on this was displayed on all the units. Staff also told us they knew there were policies and procedural guidance in place to refer to.This helped to ensure that staff had easy access to the contact details of appropriate organisation to report issues to.

The registered manager has followed local safeguarding protocols when appropriate and informed CQC about any safeguarding referrals that have been made to the local authority safeguarding team. This indicated that the registered manager has responded appropriately when it was suspected that abuse may have occurred.

Previous inspections had identified concerns with some areas of service provision areas. At that inspection we had found that people were not being protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage them safely. We found that the registered provider had not ensured that people who lived, worked and visited the home were being protected against the risks of poorly maintained premises and facilities. We also found that the provider did not have monitoring systems and procedures in operation to ensure that equipment people used as aids

Is the service safe?

to daily living was regularly visually checked to make sure it was ready for people to use. Tthere were also aspects of quality management that had not been effectively monitored to help ensure people's health and welfare.

The registered provider told us how and by what date they intended to improve the premises, infection control and the way medicines were managed. They told us that they planned to refurbish the home and provide an environment that was easier to keep clean and so maintain good infection prevention. They told us that they would review and improve their processes for record keeping, stock control and the administration of medicines. The registered provider also gave us a voluntary undertaking to take no further admissions whilst they attended to the breaches.

At this inspection we checked the provider's progress towards making these improvements. In medicines management we found that the provider had significantly improved the way medicines were managed and met the requirements of the warning notice. Medicines were administered and recorded appropriately and were being kept safely. We found that nurses giving out medicines had been assessed to make sure that they were competent in the task of handling medicines. We saw that medicines records were completed promptly and correctly.

Medicines storage was clean, tidy and secure so that medicines were fit for use. We found that storage on one unit was too warm for medicines storage but the provider was actively working to resolve the problem. We looked at the handling of medicines liable to misuse, called controlled drugs, on one unit. These were stored safely and recorded correctly and this reduced the risk of mishandling.

We checked the provider's progress on improving the environment and infection control systems. We found that a major refurbishment and upgrading of the premises and facilities was nearing completion. This included new carpets and flooring throughout the home in communal and dining areas and new furniture and soft furnishings. Areas of damaged wood work and porous work surfaces and kitchen areas had been improved to provide easily cleanable surfaces. Additional storage space had been created to help prevent clutter in the bathrooms and corridors. This helped to make the home a safe, clean and hygienic place to live.

We looked around the home and saw that all areas were clean and fresh. The domestic staff we spoke with told us that the environmental upgrade made it "much easier" for them to keep the home clean and fresh. The building was being maintained to a safe standard and regular checks on lifting equipment and wheelchairs and were being undertaken to make sure they remained safe. This met the compliance action made at the last inspection.

There were procedures in place about keeping the equipment in use clean and domestic cleaning records were also being kept. There was information and procedural guidance for care staff on hand washing and good hand hygiene and information on this was displayed throughout the home. There were supplies of personal protective clothing for staff to use to minimise the risks of the spread of infection. There were hand washing facilities including liquid soap and paper towels which enabled people who lived at the home and staff to maintain hand hygiene and reduce the risks of cross infection.

There were suitable hoists and moving aids in use in the home to assist with the different mobility needs of people living there. We noted that some slings used for moving and handling techniques had been used communally. We raised this with the registered manager and it was addressed before we left the home. The slings that had been used for more than one person were taken out of use for cleaning and individual slings provided for people. This reduced the risk of any cross infection.

We looked at the staffing levels on the four units in the home. We found that with agency staff there were enough numbers of staff to meet personal care needs.. For example, on Baden Powell unit we saw rotas for the night shift that did not indicate which staff would be on night duty. We asked staff about this and were told it was because some shifts would be covered by agency staff. For one week we saw there were no confirmed figures for staffing on the unit so skill mixes could not be assessed.

When we had arrived on Cavell unit on the morning of the inspection the night staff were still on duty. The only permanent member of the night staff on duty had gone home ill during the night. As a result staff levels had been reduced on Baden Powell units and there was one agency registered mental health nurse (RMN) covering both Cavell and Baden Powell unit. This meant that staff levels

Requires Improvement

Is the service safe?

overnight had been lower than the required establishment and all the staff on unit were agency staff, less familiar with the service and people living there. There had been no permanent staff on either of the two units overnight.

We were aware that there had been staffing shortages in the home and the registered provider had put contingency plans into operation and employed additional agency staff. We were aware that a significant number of shifts were being covered by agency staff and had been since June this year. The provider had told us that this was an interim measure while they tried to recruit suitable nursing and care staff and staff numbers were being maintained by using agency staff. The registered provider was actively trying to recruit more nursing and care staff to increase the permanent staff establishment. In the meantime the manager was still using agency nursing and care staff. The registered manager had made sure that the same agency staff were used so they had a knowledge of the service and the people living there to help reduce the risk.

We could see that risks to people and staff were being identified but not always taken into account when considering staffing on units. We looked in detail at the care records of three people on the male only Baden Powell unit whose behaviour could challenge the service. We saw that strategies had been identified for staff to help manage risks around their behaviour. On Baden Powell unit a risk had been identified, in regard to one person living on the unit, that female staff could be “at risk” from this person. However the rotas showed that there had been shifts when the skill mix had not been taken into account for this and all care staff had were female. Therefore they had to provide care and support for the person even where it had been identified that female staff were a possible trigger for certain behaviours.

We also found that the strategies agreed to manage risk and meet healthcare needs were not always subject to thorough evaluation. For example, we looked at one person’s comprehensive care plan where incidents had been recorded when they had become “agitated, upset” and “aggressive”. There was information on supporting the person when they exhibited this behaviour. However there was no evidence that these incidents had been analysed when they occurred to inform the staffing needs and skill mix on the unit where this occurred. This meant that the people may not always be supported by staff with the right skills.

Requires Improvement

Is the service effective?

Our findings

The evidence we found indicated that there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people living there could not be sure the staff caring for them had received appropriate training and supervision to meet their needs.

Staff files showed that some care and ancillary staff had received supervision but there were no verifiable up to date records of which staff had received supervision, with whom or and when. Except for a group supervision in April 2014. There were also individual records of the unit heads having had more recent supervision sessions. Staff told us that supervision was "Just starting up again" and also that it had been "Quite a while since I had an individual one but we have had some group sessions". This suggested that access to regular and structured supervision was not consistent within the service. This could result in staff not having an opportunity to have regular face to face supervision and talk through any practice issues, about their role, the needs of the people they supported and training needs.

The service had policy and procedural guidance on staff training and keeping records. We asked staff about the training, development and supervision they had received. We were told that they did a lot of training 'on line' by e-learning. We were told by some staff that they had recently done e- learning on infection control, food safety, safeguarding, fire safety and moving and handling training. One staff member told us they had not been given any time at work to do the e learning so "It would have to wait" another member of nursing staff said e-learning was" very useful" and that they they had done it at home in their own time.

Staff we spoke with also said that they felt they and colleagues were "Receptive to learning" and "Keen to learn" but with doing extra shifts they had not had time to go on line and do some training. We found that there was no training lead in the home to oversee and make sure training and staff development took place.

The registered manager was not able to show evidence of the dates when induction training for new staff was being started and completed to make sure they had received full induction training before starting work with people living there. The registered manager told us that the home's induction training followed Skills for Care's '**Common Induction Standards'** (CIS). These are the standards people working in adult social care need to meet before they can work unsupervised.

The manager confirmed that new staff were given CIS work books to work through and complete and have signed off by the unit manager. However there was no verifiable evidence to confirm this had happened with new staff. We could see when we visited the units and looked at rotas that the registered provider had not always made sure there was the right mixture of staff on each shift with the right training, skills and experience.

We also found that there were staff on the male only Baden Powell unit who had not had access to appropriate training relevant to their role and duties. This was in regard to the prevention and management of violence and aggression to help ensure they had the skills to deal with such situations. For example, the 'Management of Actual or Potential Aggression' (MAPA) is accredited training for interventions suitable for staff who work directly with people across the age spectrum who present behaviour that limits inclusion and/or that is considered to be risky or harmful to the person or others.

We asked staff on Baden Powell unit about the level of training they had on handling aggression and the use of restraint. We found that one staff member had conflict resolution training from another employer, not whilst at Heron Hill. One was aware they needed an update on MAPA training; one did not know if their training was appropriate for the client group and one staff member felt they were up to date as they had done some 'in house' training led by the manager and former deputy manager.

We looked at the training pack the manager had developed and used for in house training on managing behaviours that challenge the service. This provided useful general information to raise staff awareness and understanding of the principles involved in managing behaviours that might challenge the service. It was not accredited with an approved body to provide training suitable for staff working directly with people whose behaviour was such it limited their inclusion with other people living there. This indicated to us that staff working with people whose behaviour may challenge the service were not being effectively enabled to ensure thay had access accredited training relevant to their workplace and role.

Requires Improvement

Is the service effective?

We also asked relatives visiting the home about their observations on how staff worked with people . One relative told us, “They’re (staff) are nice and polite but don’t seem to have a good understanding of his needs, the psychology and needs to do with people’s dementia, but I know they are working hard”. Another relative told us, “I think some agency lack an understanding of people’s dementia”. Their comments indicated that relatives did not have full confidence in the specialist knowledge of some staff.

We looked at the management of medicine changes to meet people’s health care needs. We found that people who used the service had received a review of their medicines and changes had been made by their GP. We saw that these changes had and had been made correctly and promptly implemented. We saw evidence of this in records of communications with doctors and other healthcare professionals so that changes to medicines and treatments could be tracked and checked. We saw evidence that staff had organised for people to be reviewed by their GP and specialists such as their consultant psychiatrist when this had been recommended by healthcare professionals. This helped to make sure that people’s health care and treatment needs were being coordinated with appropriate health and social care professionals and agencies.

We spent time with people as they took their lunch on McKenzie unit. People received ample

portions and appeared to enjoy the food. People’s specific dietary needs and wishes such as pureed food and meals suitable for people with diabetes were provided. We saw staff ask each person what they wanted to eat from the menu. One person asked for something different to the menus choices and this was provided.

We saw that staff offered assistance in a discreet way to prompt people to eat and cut up food to make it easier for them to eat independently. Staff sat down with people who needed more help to eat their meal and adapted crockery and cutlery were used to promote independence. People were assisted to eat in an unhurried manner with staff chatting and encouraging their independence

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. The staff we spoke with knew why a Deprivation of Liberty Safeguard had recently been required for a person. Staff demonstrated an awareness of the code of practice and the process to assess someone’s capacity to make a decision..

Some people who lived at the home were not able to make important decisions about their care or lives due to living with dementia or mental health needs. We looked at care plans on the units to see how decisions had been made around their treatment choices and specifically ‘do not attempt cardio pulmonary resuscitation’ (DNACPR). We saw that people had the opportunity to make decisions about future care, treatment and their wishes should their health needs change radically and this was recorded in their plans.

We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. Personalised plans of care from GPs were in place where people had been given the opportunity to let the healthcare team know how they wanted to be looked after in future and in an emergency. We could see that decisions had been made with involvement of doctors, families and care staff and documentation indicating where a deputy had been appointed under the Court of Protection.

The registered manager of the home had a good understanding about when a Deprivation of Liberty Safeguard was required to protect an individual’s rights. Deprivation of Liberty Safeguards had been applied for and agreed appropriately for people who lived at the home. Records indicated that the correct procedure had been followed when applying to a ‘supervisory body’ for authority. This helped to make sure that people’s individual rights were promoted and respected.

Good

Is the service caring?

Our findings

People who used the service confirmed that the staff knew the support they needed and their preferences about their care. One person told us, “I have a choice in what I do, they (staff) don’t just do things without asking me”. We were also told “I think they know me pretty well”. One person told us that their appearance was very important to them and it was “Important to have my clothes right”. This was reflected as important in their care records. They told us “They (staff) all speak to me when I go for my walks round and always remark on my nice appearance”.

We asked one person what it was like living at Heron Hill and they told us “It’s moderate I would say, the staff aren’t bad, some are better than others. I would say they do listen to me and if I say I don’t like something they take it OK”. Another person told us, “Nothing really concerns me, I’d tell the nurse in charge if I was not happy, she’s very good and kind hearted, I can have a laugh and a joke with her”.

We spoke to relatives about the care people received and the attitude and approach of staff. We received comments including, “They’re (staff) nice and polite and they will ‘phone and keep me informed” and also “They’re mostly kind and caring “. Families we spoke with told us that they were able to visit their relatives whenever they wanted.

People’s privacy was being respected. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. All the bedrooms also had ensuite toilet and shower facilities so people had privacy for personal care needs. Bedrooms we saw had been personalised with people’s own belongings, such as photographs and ornaments to help people to feel at home. Throughout the time we spent in the home we saw that people had free access to their own rooms at any time and some people had chosen to spend part of the day in their room.

We saw that bedroom doors were always kept closed when people were being supported with personal care. People we spoke with told us that they saw their doctors in their own room when they visited. We saw that staff protected people's privacy by knocking on doors to private rooms before entering and providing support to people in a discreet manner. We saw that staff maintained people’s personal dignity when assisting them with mobility and in using the equipment they needed. People were well presented and we saw staff assisting people to adjust their clothing to maintain their dignity.

We saw staff talking to people in a polite and friendly manner and including them in general conversations. Staff called people by the preferred names that were in their care plans. Staff we spoke with were able to tell us about people’s preferences and social interests such as what television programmes, music and DVD’s they liked.

We used the Short Observation Framework for Inspection (SOFI) to assess how people in dining and communal areas were supported by the staff on duty. We saw that staff took the time to speak with people and took up opportunities to interact with them. We saw that people who could not easily speak with us were comfortable and relaxed with the staff that were supporting them people were encouraged to do as much for themselves as they were able to.

Care records contained information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had discussed with people if they wished to be resuscitated. Staff had not attended specific training on end of life care but the registered manager was in contact with a local hospice to arrange this and to take part in 'The Six Steps' palliative care programme. This programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care.

We looked in detail at six people’s care records and other associated documentation. We saw evidence people who lived at the home, and/or their family members had been involved with planning and reviewing care and developing background information. This demonstrated that people were encouraged to express their views about how their care was delivered and what mattered to them. For example about care if their condition deteriorated or everyday matters like having a glass of red wine with their meal.

Some people used items of equipment to maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their

Good

Is the service caring?

independence and ensured this was provided when they needed it. This included providing walking frames, seat cushions and the confident use of moving and handling equipment.

Requires Improvement

Is the service responsive?

Our findings

We could see that people's families had been involved in gathering background information and life stories about people to help inform the care plans for staff. We also found that people had been involved in planning their preferred routines. For example, when they preferred to get up and go to bed in the evening and where they wanted to take their meals or if they wanted to attend religious services in the home. People were supported to practice their faith. The home had multi-denomination services and people's own priests or clergy could visit as people wanted.

People told us they knew they could make a complaint and that there was a complaints procedure. We could see that a copy of the complaints procedure was on the back of people's bedroom doors. However the information was high up and not in large print so making access more difficult for wheelchair users or people with visual impairments. One person told us, "I haven't had to complain yet, so far if I want anything changing I just tell the nurse". Another person told us "I have never really thought about making a complaint, not sure how to, just tell the nurse and let them get on with it". People we spoke with said they were not afraid to make a complaint and if they did it was to the nurse in charge. The registered manager told us that they had an "open door" policy and people, relatives and staff were welcome to speak with them and raise any concerns they had.

We asked relatives about how the service had responded if they had made a complaint or raised any issues with the unit managers or registered manager. One told us "I complained to the regional manager and the operations manager and they (relative) are getting the right care now". People's relatives told us they felt comfortable talking to staff and were able to raise any concerns. They felt their concerns would be listened to and dealt with appropriately.

We saw that complaints were recorded and the action taken in response to complaints had been recorded and had been dealt with by the registered manager or senior managers. Records indicated that the registered manager had referred one complaint to safeguarding agencies when they had received it and taken immediate action to protect people. The evidence available indicated that the registered provider and registered manager responded when a complaint was made.

We found that the home had only one activities coordinator working across all the four units in the home. There had previously been three activities staff to provide individual and organised group activities for people with a variety of needs. One person who lived there told us, "There's not much going on at the moment". A relative said "They (relative) needs more mental stimulation.

We asked staff on McKenzie unit when the coordinator came in and they told us they came in on Tuesdays and Thursdays. A staff member also said that "When we have time we will sit and chat to people about their lives before coming to live here". However a relative commented that they felt staff were "Already overstretched doing basic care never mind activities". This indicated that organised activities were not being well supported by the registered provider.

When we visited the activities person was on McKenzie unit playing music for people in the lounge. People with failing health who spent time being cared for in their rooms on the units were not able to be included in such events and this could mean they did not receive the support they needed to avoid social isolation.

The reduced level of dedicated activities staffing could result in people not being given the opportunity to follow their interests and be supported to take part in social gatherings. At the time of our visit there were 63 people living in the home with a range of social needs and interests. People's care plans all indicated their own interests and what they would like to take part in but we did not see anyone receiving individual support to pursue their own interests or be supported go out into the community except with their relatives.

We looked at care plans and at the way people were supported if they received 'covert'or hidden administration . This was in respect of needing a 'when required' sedative and we saw the plan was lacking in detail and guidance on the way this was to be done and why. A lack of information in care planning for staff could result in a person not being protected against inappropriate methods of administration. We also looked at the care plans for the management of pain and its relief and in detail for a person who had communication problems and was registered blind. The plan in place failed to provide sufficient guidance on the assessment of pain with specific regard to

Is the service responsive?

the people with verbal and sensory difficulties. This lack of planning could mean that the person might not be given the support to inform staff about their pain relief needed to keep them free from pain.

Care plans showed that assessments had been done to identify people's care and support needs both before and on admission. Care plans had been developed from the initial assessments saying how needs should be met. We saw that care plans had been reviewed as people's needs had changed. The information in the plan meant that staff should know what support people required. For example, we saw the records for one person of a wound plan being assessed daily and stating how the wounds were being dressed and any changes or improvement. We saw that risk control measures were in place including the provision of appropriate equipment to help prevent skin damage.

However, on Baden Powell unit we found a care plan for a person whose care plan stated they preferred to have their meals in the lounge area as they became agitated in the dining area. However the nurse took them into the dining area to have their meal. The nurse did not normally work on that unit and so was not familiar with people's individual needs. This action contradicted the agreed care plan to help manage their agitation at meal times and indicated that care may not be provided consistently to meet individual preferences.

People's care plans included risk assessments for pressure care, falls, moving and handling and mobility and nutrition. We found people had been assessed to determine whether they were at risk of malnutrition. We saw that care plans reflected nutritional needs and where there were risks from choking. We could see that the Speech and Language Therapist (SALT) had assessed people's choking risks and plans had been put in care following their advice and guidance, such as using fortified drinks and thickening agents to reduce choking risks.

We could see that expert advice had been sought when planning aspects of care. For example, the inclusion of an occupational therapist (OT) to assess a person for a specific type of chair. Care planning included the guidance provided by the OT on how to seat the person correctly in the chair. During the inspection we saw that the guidance had been followed with regard to how the person was positioned in the chair.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the CQC. The registered manager had been in post since April 2014.

The evidence we found indicated to us a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the registered provider and registered manager had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness.

The registered provider had a system in place for the registered manager to monitor and report back to them on quality monitoring issues and assurance monthly. This required the registered manager to carrying out detailed monthly audits and send the findings of their checks to the provider as part of a larger organisational quality monitoring system. This comprehensive audit was called the 'Home Manager Monthly Audit' and covered all aspects of the service including record keeping, training, activities provision, staffing. The records provided to us indicated that this system had not beenfully implemented recently and records of the last audit were from June/ July 2014.

We found that monitoring systems had not always been put into practice effectively and had not been followed up formally in some areas. For example, staff training and development had not been effectively monitored to make sure that all staff induction, ongoing training and supervision had been done. Therefore we could not assess the levels of staff training in the home. The home's own training policies and procedures stated that it was the home manager's responsibility to make sure all statutory training was up to date and to update the training matrix when training had taken place. This meant that people living in the home could not be certain that the staff caring for them had the right skills and training to do so and were being supported in the roles and duties.

We found that although care plan reviews were being done we saw care plans that were not accurate. For example, one care plan had out of date and inaccurate information about using restraint for a person. This was not the approach that was stated in the current multi-agency care plan that was in place to support the person. The care plan audits had not picked up this out of date and conflicting information.

We saw that the depth of information in care plans relating to the support people needed to receive medicines and treatment varied. Whereas some were good, we found others were lacking in detail. For example, we looked at care plans for two people who received medicines to help control seizures. There were no care plans in place to provide guidance for staff on action to take if people should suffer seizures. This ommission had not been picked up during the care plan or medicines audits. In these cases staff could take an incorrect approach action as no one had noted the incorrect information during previous audits.

We spoke with the registered manager about the inconsistency in the regularity and effectiveness of the audit system. The registered manager had been on sick leave and there had been changes in staffing and staff shortages. The outcome had been a period when great attention had been paid to improving quality monitoring in areas that were non compliant at the last inspection whilst other areas had received less verifiablechecks. The registered manager was able to show us the documentation and explain the process he was now implementing to make sure the management audits would be done that month.

Staff we spoke with told us that it had been difficult to keep on top of auditing and checks when the manager was off and staff levels were under pressure and there had not been a deputy manager in post. We were told, "Things fell apart when the manager was off, there was so little consistency". We were told that "Things did slip when staffing was so low". Staff also told us that, "It's improving gradually" and also "Morale is improving" and also "It's so much nicer now the refurbishment is being done".

We looked at the records of accidents and incidents that had occurred in the home on the units. We did this to check if action had been taken promptly to analyse any incidents and make changes if needed. We saw that incidents had been recorded and followed up formally with appropriate agencies or individuals where needed. However there was no verifiable evidence that the registered manager analysed incidents for patterns or trends so they could take formal action to reduce any situations happening again. The registered manager was aware of the need to reinstate this activity.

Maintenance checks were being done regularly by staff and records kept. Faults had been highlighted and acted upon. There was a comprehensive cleaning audit on premises

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and equipment to make sure they were clean and safe to use. These were all areas that had been highlighted at the last inspection and were being well monitored. Hygiene and hand washing audits had been done to help make sure staff understood about the need for good hand hygiene and promote good practice.

We could see that considerable financial resources had been put into the major refurbishment of the home to make the environment and hygiene systems effective and safe. The registered provider had also put considerable financial resources into using high numbers of agency staff to help maintain staff numbers on units. This indicated that the Registered provider was committed to trying to improve the home for those who lived there.

Staff told us the unit managers and registered manager were accessible and approachable. We were told by staff that they had confidence in the registered manager and unit manager to address any concerns they had. We were told by a member of staff that they had spoken to their unit manager and registered manager about some concerns they had over some practices they had seen. The concerns were taken up and action was taken. They person told us they had no hesitation taking forward any bad practice issues with the management.

Staff told us that they had staff meetings to discuss matters and promote communication about what was going on and we saw records of these. We were told that now the manager was back they expected these to carry on as before. This was the same for residents meetings as they had also less frequent in the previous months. The registered manager had sent out satisfaction surveys in March 2014 but there had been little response and there was no collated information to assess.

At the end of our inspection we shared an overview of our findings with the registered manager. The registered manager of the home told us the actions they intended taken to address the areas that needed to be improved. This indicated to us that the registered manager was open to feedback to improve the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: There was not verifiable evidence that all staff in the home had received induction training, appropriate training for their roles or regular supervision and appraisal to monitor their performance. People living there could not be sure the staff caring for them had received appropriate training and supervision to meet their needs Regulation 23 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People were not being protected against the risk of unsafe care because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. Regulation 10