Silverline Care Limited

Linson Court

Inspection report

Dark Lane
Batley
West Yorkshire
WF17 5RU

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07 February 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 31 January and 7 February 2017 and was unannounced. The service was last inspected in December 2015 and was found to be in breach of five regulations.

Following the last inspection, requirement notices for regulations 9, 11,12 and 13 and a warning notice for regulation 17, good governance had been issued to the provider. Several aspects of the warning notice had not been sufficiently addressed by the provider and significant concerns remained at this inspection.

Linson Court is registered to provide residential and nursing care for up to 40 people in single rooms with en-suite facilities. The bedrooms are situated on two levels with a lift and stairs for people to access the first floor.

The home had been without a registered manager and a manager had been in post since August 2016. They were in the process of registering with the Care Quality Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Linson Court was welcoming and provided a homely environment. Staff had an understanding of how to keep people safe and knew the safeguarding procedures to follow in the event of a concern or allegation of abuse.

Individual risks to people were not always assessed and there was little analysis of accidents or incidents. There was poor oversight of clinical risks to those people who required nursing care and we found weaknesses in medicines management.

Staffing levels were managed appropriately to meet people's needs, although induction for new staff lacked recorded detail and recruitment was not consistently robust. There were gaps in staff training, knowledge and supervision and there was little evidence staff competencies were checked, particularly around skills required for providing nursing care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff had received training on the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards and staff understood this. Where people had care plans completed thoroughly there were recorded details of mental capacity and some best interest discussions. However, not all people's information was recorded appropriately and some people did not have a care plan in place or any assessment of mental capacity.

Food provision was of good quality and people enjoyed the meals overall. There was a designated chef who

understood the importance of diet and nutrition and was involved in the serving of the meals, so knew people's preferences. However, there was poor monitoring of people's dietary and fluid intake. Records of weight monitoring were not maintained regularly; the records that were available showed several people had lost weight, yet there was no oversight of this or evidence of action taken.

Staff had good relationships with people and they knew each person well. There was plenty of friendly banter and a happy atmosphere in the home. Staff respected people's privacy and dignity in care practice although some confidential information was on view in communal areas.

Where people were approaching the end of their life, staff were attentive and compassionate, however, relevant care planning was not always given due consideration.

Staff offered person centred care in the way they interacted with people and supported their needs. Activities were meaningful and staff made frequent checks on people who stayed in their rooms. Care records were variable in quality; some had more detail than others, although some lacked essential information.

Complaints were not always responded to appropriately; where people complained verbally this was not recorded and there was no evidence matters had been satisfactorily addressed.

The management of the home was unsettled and staff lacked clear direction in their work, although staff said they had better support than before the manager was in post. There was no clinical leadership or oversight of nursing care in the home.

This inspection highlighted continued breaches in four out of five regulations identified at the previous inspection and three further breaches.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not sufficiently detailed or in place to ensure people's safe care and treatment.

Medicines were not managed safely.

There was no analysis of accidents or incidents to establish lessons learned or prevent a re-occurrence.

Is the service effective?

Inadequate

The service was not effective.

Staff competencies were not assessed or monitored to ensure they had the skills to carry out their role effectively.

Handover documentation was poor, particularly in relation to people's nursing care.

People's nutrition and hydration needs were not sufficiently monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff demonstrated a patient and caring approach when interacting directly with people and relationships were kind and supportive.

People's dignity and privacy was respected when staff supported them with personal care.

People's end of life care was delivered in a sensitive and compassionate way, although end of life plans were not always in place.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were incomplete and held inconsistent information. Information about people's care was not always recorded accurately or easy to locate.

Staff made time to interact socially with people and ensure they were occupied

Complaints were not all recorded or responded to, although people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

The manager was not always visible in the service and there was little clinical leadership in the home.

Systems and processes for monitoring the quality of the provision were not robustly in place.

Concerns identified at the previous inspection had not been sufficiently addressed.

Linson Court

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 31 January and 7 February 2017 and was unannounced. The previous inspection was in December 2015.

There were two adult social care inspectors. Before the inspection we reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

We spoke with seven people living at Linson Court and four relatives and visitors. We spoke with the regional manager, the manager, two nurses, three care assistants and the chef during our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We observed the lunch time meal experience in the communal dining areas and observed care interventions throughout the inspection process. We reviewed seven care files and daily records for people living there . We also reviewed the maintenance and audit records for the home.

Inadequate

Is the service safe?

Our findings

People we spoke with said they felt safe at the home. One person said, "I'm safe in this place, it's the right place for me". Another person said, "The staff know me and how to keep me safe. I would struggle if I lived on my own." Relatives we spoke with said they did not have concerns about safety in the home. One relative said, "There's always staff around to make sure my [family member] is safe. We have peace of mind."

Staff told us they knew how to notice the signs of possible abuse and if they had any concerns they would report them immediately to their line manager. One member of staff said they were confident to challenge any poor practice if this compromised people's safety or wellbeing and they would be supported to use the whistleblowing procedures to do this. It was not clear from the training matrix when staff had undertaken safeguarding training as this was all dated 12 January 2016.

We had safeguarding concerns about two people in the home; one person who had only taken minimal food or fluids for three days and another who had a deterioration in a skin wound. Both of these people had poor care recording so it was not possible to see what had been done to manage these situations and staff could not confirm what action had been taken. We asked the manager to refer these people to the local safeguarding authority and they confirmed they had done this.

Staff we spoke with knew what to do in the event of an emergency and the maintenance staff told us they made regular checks of the fire alarm system, premises and equipment. We reviewed documentation for the safety of premises and equipment and found certificates were up to date to show these had been inspected.

However, we found upon looking round the premises two downstairs bathrooms were out of action; one had no hot water and the last recorded water temperature was 29 November 2016. The bath temperature record sheet stated 'bath been broken, not able to use'. In the other bathroom the bath hoist seat had a sign which stated 'Please do not use out of order 10.12.16'. We asked staff how people were supported to have a bath if both of these bathrooms were not in use and staff said people could be supported to use the other bathrooms on the first floor. We spoke with the manager about any action taken to resolve this issue but they were unable to confirm whether anything had been done about it.

Accidents and incidents were recorded, but there was no analysis done within the home to establish if trends or patterns occurred or learn from lessons around these. The manager told us accident and incident information was sent to senior managers within the organisation to review, but there was no review of the information done at home level. This meant it was not possible to establish what lessons had been learned from incidents, such as medication errors. We saw from accident and incident records there had been serious incidents, such as choking on food and medication errors, but there was no clear indication of what action had been taken to avoid a reoccurrence.

Individual risks to people were not always managed well. Where staff knew people well, they were aware of people's abilities and potential hazards to them, but where people were new to the home, risk assessments had not been completed or measures put in place to ensure their individual safety. For example, one person

who was new, had been admitted to the home with a history of falls, yet no assessment of this was carried out to ensure they had the correct support or equipment in place. Where changes to people's risks occurred this was not always documented. For example, one person had a choking incident, yet there was no assessment of the risk following this. For people who needed thickening agent adding to drinks to minimise the risk of choking, we saw this was stored accessibly within their rooms. However, this substance is potentially hazardous if swallowed undiluted and it was not securely stored.

Where people had risk assessments in their care records we found these were often grouped together and had no resemblance to one another. For example, confusion, falls, tissue viability and pain were included together in one plan without key points for staff to understand the individual risks or how to ensure people were safely supported. Moving and handling risk assessments were completed but only in a very basic way; there was no indication other than a 'tick' of the equipment needed or the method staff were to follow to support a person safely. Staff told us people used the shower chair, although there was no assessment for the safe use of this equipment in any of the care plans.

The management of risks had been a concern at the last inspection and insufficient action had been taken by the provider to address this.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12(2)(a)(b), safe care and treatment.

Staffing levels were appropriate to meet people's needs and we saw staff spent time in care tasks and in conversation to support people's physical emotional and social needs. Staff rotas showed sufficient staff were allocated to each shift and the manager had introduced an allocations list for each day to show where each staff member was deployed. Staff recruitment procedures were in place although not robustly implemented. Disclosure and barring service (DBS) checks and two references were sought as well as applicants' employment history, although one staff file we looked at only contained one reference.

Staff we spoke with said their induction had enabled them to shadow more experienced staff and this helped them get to know people and their needs.

We looked at how medicines were managed. We saw staff supported people patiently, obtaining their consent before applying creams or eye drops and there was good communication throughout. People were asked if they had any pain and offered pain relief medicines as required (PRN). There were some PRN protocols in place to guide staff when these may be needed, although some people who had PRN medicines did not have a protocol in place. This had been a concern at the last inspection and insufficient action had been taken by the provider to address this.

We found a tablet on the floor of a person who was asleep in their armchair in the lounge. We gave this tablet to the nurse who said they had thought the person swallowed it.

Each person had their medicines stored individually in a locked cabinet within their own room, apart from controlled drugs, which were secured in locked cabinets within the treatment room. We carried out a sample of one person's controlled drugs and the nurse in charge showed us the records tallied with the amount stored, with clear recording of when this had been given. Where supplementary drinks had been prescribed for people we found these were sometimes stored within their rooms. The nurse in charge told us these should be stored securely in the treatment room until ready for use and they were in the process of improving practice around this.

We found weak systems and processes in place for the storage and management of medicines to be returned or disposed of. For example we found all staff had access to the locked upstairs treatment room because this was where care records were also kept. In this treatment room there were large quantities of medicines stored insecurely; some were in two cardboard boxes on the floor and some with in a yellow bin with an ill fitting lid which was placed loosely on top. We spoke with the nurse in charge who could not account for the medicines stored in this way or say how many or what the drugs were. They agreed these medicines were able to be removed by any of the staff in the home and there was potential for misuse.

We looked at the medicines administration records (MARs) for a sample of seven people and we saw there were gaps in the recording of when medicine had been given for five people from the sample we chose. This meant it was not possible to see if people had been given their medicines as they needed them. Where one particular medicine required a person's pulse to be taken first, this was not consistently recorded. This indicated the person's pulse rate may not have been taken and therefore the medicine may not have been safe to give.

One person's MAR included a letter from the GP to state their medicines could be crushed and given covertly. Staff could not confirm this had been discussed and agreed by the pharmacist as safe to administer in this way. We looked in the person's care records and there was no information to show this had been discussed with the person or their representatives as appropriate. For another person who was new to the home, the handover notes stated 'can hide medication' yet there was no authorisation for staff to do so or evidence of this being thoroughly discussed and agreed. This had been a concern at the last inspection and insufficient action had been taken by the provider to address this.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12(2)(g), safe care and treatment.

The home was visibly clean and there were no malodours. Staff used personal protective equipment effectively. We saw a daily cleaning check had been updated although not every day. Staff we spoke with understood how to prevent the spread of infection through hygienic practice and we saw there were posters up to remind staff how long to wash their hands for in order to prevent the spread of infection, by singing the 'happy birthday' song.

Inadequate

Is the service effective?

Our findings

People we spoke with said gave their views on whether they thought staff were skilled in their roles. One person said, "They are good, I'll say that much, they know what I need". Another person said, "They can't always sort my pain out but I don't think that's their fault". Another person said, "Aye, they know what to do with me" and another person said, "Both carers who have been in this morning are tip top, I'm very happy here". Relatives we spoke with said they thought staff were able to do their jobs sufficiently well. One relative said, "The staff are helpful" and another relative said, "They seem to know what they're doing, I would imagine they have the right training".

We looked at the staff training matrix and found there were gaps which suggested not all staff had the right level of training to ensure they were able to support people effectively. For example, some staff had not undertaken moving and handling training, although this was scheduled.

We spoke with the manager about how staff competency in their role was checked. We were told staff there was no consistent system for checking staff competence. We found nurses completed self competency forms to declare they were competent to administer medicines and the manager checked these forms. However, there were no competency checks for other staff. The nurse we spoke with said they checked to see senior care staff were competent at giving medicines, but there were no records to support this. There was little evidence qualified nurses had any clinical development training.

We spoke with the nurse in charge who was unable to tell us how many people required nursing care. They told us it was the nurse's responsibility to have an oversight of the key risks with regard to nursing care on each shift, but they said they did not always have the time allocated to do this. They acknowledged this was not always managed effectively. They told us there were a high number of agency nurses used and this meant there was a lack of continuity or responsibility taken for key tasks and clinical leadership.

We found supervision meetings with staff were not carried out with consistency. The manager told us they had plans to ensure supervision meetings were scheduled although this had not yet happened on a regular basis to ensure staff were supported effectively. We found there was no direct one to one supervision for nurses. The manager told us no appraisals had been completed.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (2)(a), staffing.

Staff told us they felt they had more support since the manager had come into post in August 2016, although they said there had been a disruption during the manager's recent unexpected absence. Staff meeting minutes were available to show these had taken place from August to October 2016.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw from the training matrix staff had received training in MCA and DoLS and we found through speaking with staff they understood how the legislation affected people's care and support.

Where people had care plans there were some recorded details of mental capacity and best interest discussions for most decisions. However, for one person whose medicines were given covertly, there was no evidence of this having been discussed with them or their representatives as appropriate. Not all people had a care plan in place and therefore mental capacity assessments had not been considered for these people. One person's care record stated 'has dementia' yet there was no mental capacity assessment and no evidence of consent, such as for bedrails use. Consent and best interest forms in this person's care record were blank.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11, need for consent

We saw staff asked people's consent when they supported them within the routine of the day, such as where they might like to sit and what they wanted to eat, drink or do. One person we spoke with said, "They always ask me first about whatever it is I might need help with".

We saw people were regularly offered meals, drinks and snacks at regular intervals throughout the day. However, we noted people had to wait a long time in the morning before being offered a drink. One person said, "I always get up early but I have to wait until breakfast time for a cup of tea". Another person said, "We just have to wait". This person told us they had been up for three hours and they had not been offered a drink. Another person said, "I'm not bothered, they have to see to everyone so I can wait my turn".

People were offered a choice of food, although we saw staff asked people a long time in advance of their meal, which meant they may not remember their choice by the time the meal came. For example, one member of staff asked people what they wanted for both lunch and tea. They commented, "I know it's a bit early to ask what you want for tea, but the tea list has to be done". Staff we spoke with told us people were able to change their mind, or if they did not want a particular meal, alternatives were offered.

People told us they enjoyed the food and drinks available at Linson Court. One person said, "The food here is very good, it's how I like it". One relative said, "Breakfast has changed to 9am-10am, it's not ideal". Another relative said, "Meals are very good, they always say if you want more you can have more."

There was a notice board in each dining area which outlined the dining room protocols and gave staff information of people's particular dietary needs, such as who required thickened fluids or pureed meals. The manager told us they had sought advice and input for staff around people's dietary needs from the speech and language therapy (SALT) team. Staff we spoke with were aware which people were at high risk of choking and how to ensure they had the correct amount of thickener in their drinks to minimise this risk.

We saw there was a clear procedure in place to ensure people were served their meals in a timely way without having to wait and this enabled staff to deliver the meal service efficiently in line with people's needs. Mealtimes were observed to be calm and relaxed occasions with staff communicating well to meet

people's needs.

We spoke with the chef who was enthusiastic about their role and they told us how they worked alongside the staff team to meet people's dietary needs. They showed us how each person had a diet modification form which listed allergies, likes, dislikes and special requirements. The chef told us how they fortified foods for people who needed additional calories and how they helped to serve the meals to people alongside care staff. The chef told us they sourced the food appropriately and this was stored in line with good practice. For example, the Universal Halal Agency gave a certificate of halal accreditation for site and processing.

We saw staff took meals to people who stayed in their rooms and offered one to one support where this was needed. Staff gave plenty of encouragement for people who were reluctant to eat or drink and they recorded people's food and fluid intake. We saw however, where recording showed people were repeatedly refusing food and drink or taking very little, this information was not reviewed in order to take timely action. For example, we saw one person's food and fluid records showed they had only 50ml of drink a day for three consecutive days, and for two of the days all of their food was recorded as 'declined', yet there was no evidence of any action taken to support the person's health. Furthermore, there was no evidence on the handover notes of any concerns for staff on the receiving shift to be aware of.

Staff told us people were weighed regularly and more frequently if there were concerns. We asked to see the weight records for people in the home. For people living on the upstairs unit we found only sparse handwritten notes recording people's weight for the months of November 2016, January and February 2017, no weights recorded for December 2016. Our review of these records showed out of 19 people, 13 had recorded weight loss. Where one person had a recorded loss of 5.1kg from November to January, we saw there was no further weight recorded or any evidence to show how this was being monitored.

For people living on the downstairs unit we found handwritten records for the months August to November 2016 and these gave details of people's room numbers, not names, so it was not possible to identify people or show where new people occupied the rooms. We reviewed records for December 2016 and January 2017 which showed people's names against room numbers. We saw only six people had recorded weights for December 2016 and two of these had recorded weight loss from the previous month.

Some care plans we looked at showed referrals had been made to dietician and SALT team when weight loss was noted, and there was detailed recording of people's risks of malnutrition using a malnutrition universal screening tool (MUST). However for some people documentation was not always in place, even when people were known to be high risk. For example, one person came into the home because they were high risk of malnutrition and weight loss, yet there was no care plan around the risks of this to the person's health.

Failure to address the risk that people's nutritional and hydration needs were not being met had been a concern at the last inspection and insufficient action had been taken by the provider to address this.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 meeting nutritional and hydration needs.

People's care records showed where people had involvement with other professionals, such as GPs, tissue viability nurses. Where other professionals had been consulted it was not always clear from care records what action was being taken. For example, one person with a skin wound was referred to the tissue viability nurse, but their body map stated only where the wound was, not the care plan for this.

Requires Improvement

Is the service caring?

Our findings

People said they felt well cared for and they spoke positively about the staff. One person said; "Oh it's lovely here, my family can come whenever they like, but the staff are like my family as well". Another person said, "I know they take good care of me, I can tell". Another person said, "I'm not complaining, they care about us in here". One person told us, "Staff are caring, they listen to me. They've always been a very good home. In the past six years I've stayed in five or six places but this is the best I've ever seen."

Relatives we spoke with said they thought staff were caring. One relative said, "I don't have any problems with how they care for [my family member]. It's as good as I expect it to be". Another relative said, "This job isn't the easiest but they always manage to show they care". Another relative said, "Staff are caring" and another said, "Staff are kind, they cheer [my family member] up. These girls on today are very caring and do this job because they want to".

Staff we spoke with told us they cared about the people they supported. Staff told us they cared for people as though they were their own family.

Staff were inclusive of people's individual religious, cultural spiritual and social needs. One person said their faith was important to them and we saw they had their own religious symbols, objects and music within their rooms. Where people needed a halal diet, the chef was able to source, store and serve the food appropriately in line with religious beliefs.

We saw staff had positive relationships with people and their direct interaction was caring and supportive. Staff spoke with people in a respectful manner and they patiently supported people at their own pace, without them feeling rushed or hurried. However, when staff discussed people's care with one another, they referred to room numbers, rather than people's names and terminology used to speak about people's needs was not always respectful. For example, staff referred to one person who needed a special diet as 'a soft'. Staff greeted people with friendly smiles and good eye contact when they came into a room, or passed people in the corridor and we saw happy banter taking place throughout the inspection.

People were appropriately dressed and staff took care to ensure they had essential items, such as glasses, hearing aids and suitable footwear. Staff ensured people were comfortable and adjusted cushions to help people feel more supported when seated. We overheard conversations between staff and people which showed staff noticed people may need support or reassurance, without having to be asked. For example, one member of staff watched a person wake up and they appeared confused. The member of staff spoke gently with the person saying, "Have you had a nice sleep? It's nearly time for tea. Do you feel alright?" then stayed with the person for a few minutes.

People's independence was promoted well and staff encouraged people to do as much for themselves as they could. Staff showed respect for people's privacy and dignity when offering support for personal care. Confidentiality of records was not always maintained as we saw some documentation with people's personal information on view in one of the dining areas.

People who were at the end of their life did not always have a clear plan in place for their wishes in the last days, even when this was anticipated. We saw staff made regular checks of people to ensure they were comfortable and welcomed relatives to visit when they wished to and afforded privacy to families who wished to stay for any length of time. For some people, the end of life care plan was blank and for others it was completed in more detail, however, one plan we saw was dated 2013 and there was no evidence of a recent review.

This illustrated the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9, person-centred care.

We spoke with some relatives whose family member was receiving end of life care. One said, "What I've found is carers have been really good, shown dignity towards [my family member] and [they] look well when we have been to see [them].

Inadequate

Is the service responsive?

Our findings

People said the care provided was responsive to their needs. One person said, "The staff know me well to know what I like. I've plenty to do". Another person said, "It's all very good here, my needs are met". Another person said, "They wash me every morning, put cream on my feet. If I had any concerns my [relative] would complain." Another person said, "If I ask I can go out. I've been out this morning to the bank, one of the girls took me. It's nice to get out. People here are lovely and if I want to go out they always find someone to help me and get a taxi."

One relative we spoke said the staff tried to make their family member comfortable by supporting them to change their position. They told us staff used a pictorial book to assist their family member with communication and said, "So far, very happy with the service" although they also commented the mealtime routine of the day was not based around individual needs. Another relative said, "Staff are helpful." One relative told us their family member was settling in as they were new to the home. They said staff had asked some initial questions to help understand their family member's needs.

We looked at people's care records and saw these were varied in content and quality of information. Some records we looked at were detailed and contained all relevant information, such as named staff member, pre-assessment and ongoing assessment of health needs and risks, individual preferences for aspects of care and detailed daily records. However, for some people information was not detailed sufficiently for staff to understand how to offer appropriate support or manage risks to their health and safety. For three people who had recently moved into the home, we saw there were no care plans or risk assessments, even when pre-admission information stated there were significant risks.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17(2)(a)(b)(c), good governance

We raised this concern with the manager on the first day of the inspection and they agreed to address this immediately. We saw on the second day of the inspection, care plans and risk assessments had been written for the three people who had no care plan in place.

The manager told us a high percentage of people spent their time in their own rooms and we saw this during the inspection. Some people were nursed in bed and upon speaking with them and looking at their care records it was evident this was their choice. One person told us, "I prefer my own company. I could go and sit out there, but I'm alright where I am." Another person told us, "I just like being here, my own things are round me and I can talk to my family when they come and visit."

We saw the activities co-ordinator spent time speaking with people on an individual basis. When people were in communal lounges we heard staff ask them if they would like to watch a film. The activities coordinator invited people to choose the film and made sure people were positioned so they could see and hear. Where one person needed their glasses, staff noticed they did not have them and went to bring them for them to wear. The film sparked conversation and people's memories about cinema trips they had

enjoyed. There was an activities timetable displayed which stated there would be 'bowling' for one of the days of the inspection, although we did not see this take place.

We saw staff understood people's needs in the daily routine. For example, where people needed to be seated on a pressure cushion this was in place. We noticed people's personal care needs were met; gentlemen were clean shaven and people were supported to use the toilet when necessary.

People we spoke with and their relatives said they knew how to complain if they were unhappy with the service or any aspect of care. They told us the manager and the staff were all approachable to raise any matters with, but one relative said their concerns were not always acted upon. We saw one relative approached the manager and voiced some concerns about their family member's care. However, we found upon speaking with the manager that verbally expressed concerns and complaints were not dealt with as part of the procedure for managing complaints.

The complaints procedure was displayed in the home. We asked to see the record of complaints received. The manager told us concerns were recorded on a piece of paper, but there was no structure to this.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16, receiving and acting on complaints

We saw written complaints were responded to and any relevant information was referred to safeguarding where this was necessary. We also saw compliments in the form of thank you cards which were displayed in the reception area.

Inadequate

Is the service well-led?

Our findings

People we spoke with said they knew there was a new manager in post. One person said, "I know who's in charge, they're not bad." Another person said, "The place seems to run alright, I don't know of any problems." One relative we spoke with said, "The new manager came and we thought things would improve but they then went off for a bit and we never see them."

There was a manager in post who was in the process of becoming registered with CQC. They told us they had been there since August 2016 and they were aware of the strengths and areas to improve after a period of unsettled management in the home. However, the manager said they had an unexpected period of absence in December 2016 and they said progress had slowed down during this time. They told us 'things had gone backwards' in their absence. They said there was an open door policy for staff to come and see them any time. We found the manager was based mostly in the lower ground floor due to the location of the office, not immediately accessible to people, staff or visitors. This meant they were not always visible in the service.

Staff we spoke with told us they thought the manager was beginning to make a difference and they had seen improvements in the way the home was run. They said they felt supported in their work and we saw evidence of teamwork in aiming to ensure people's needs were met. One member of staff said, "I like the new manager, [they are] approachable, I feel comfortable to go to [them]".

The manager told us since they came into post they had assessed the areas to improve and this was a work in progress. They told us they had reduced the use of agency staff and devised an allocation sheet to improve staff focus and direction in the home. The manager told us their biggest challenge was ensuring stability of management in the home, but felt there was a stronger staff team than previously.

The manager had external visits from managers within the wider organisation and they told us they felt supported by these. The manager was also supported by a deputy manager who had recently been appointed and who was also a registered nurse working in the home. The deputy manager told us they were unable to support the manager as well as they should because they did not have time to do anything other than nursing tasks.

We found there was a lack of clinical leadership in the home or any oversight of risks, particularly for the people who required nursing care, and staff lacked direction. Nursing staff were unable to say how many people needed nursing care and what the key risks were to their health. Agency nurses were frequently used with little handover information for them to understand their responsibilities each shift. Agency staff told us they relied upon information within the handover document to alert them to significant information. However, we saw the handover sheets lacked key details, such as malnutrition or mobility risks. There was an agency staff induction check sheet but we found this was not consistently used.

Audits in relation to the kitchen management were in place and regularly updated by the chef. However, we found audits relating to people's care were not robustly implemented and there were inaccuracies in the

information recorded where audits were carried out. For example, the medication audit had only been done since December 2016 and there were no dates to show which day this was completed and sections of the audit form were left blank. The deputy manager carried out the audit, yet their own medicines competencies had not been checked. The pharmacy audit carried out in November 2016 was revisited in January 2017 and showed there were issues still outstanding and there was no evidence to show what action had been taken.

Only two care plan audits had been completed and there was no mechanism for ensuring care plan information was in place or regularly reviewed. We saw one person's care plan had an audit done on 8 January 2017 which stated their weight was recorded monthly, yet we saw this had not been done since 11 November 2016, in spite a weight loss recorded at that time. This meant the audits were not accurate and not effective in establishing action needed to mitigate risks to people.

The manager told us the maintenance staff were responsible for ensuring premises and equipment safety. The manager told us they carried out visual checks of premises and general safety and practise as they walked around the home. They said they tried to do this daily and picked up on issues as they arose, although did not record details of this and there was little evidence of issues being followed up, such as repairs to the bathrooms. We saw mattress audits had been conducted by an external company but when we scrutinised the information we found only two out of 16 pressure reducing mattresses had been tested and 14 out of 21 other mattresses had been tested.

The manager told us there were future plans to improve the quality of record keeping and auditing by using information technology and these plans were soon to be introduced.

The above examples illustrate the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17(2)(a)(b)(c), good governance

Following the last inspection, a warning notice had been issued to the provider for regulation 17, good governance. Several aspects of the warning notice had not been sufficiently addressed by the provider and significant concerns remained at this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's end of life wishes had not been obtained and there was no end of life care planning in place for some people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always obtained from people for personal care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration assessments were not sufficiently carried out.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always recorded or acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing There were no checks made to ensure the competence of staff in their role, particularly in relation to staff providing nursing care and

Treatment of disease, disorder or injury	medication.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people were not always assessed or mitigated. There was unsafe management of medicines.

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was little assessment and monitoring of the quality of the provision and there was a lack of clinical leadership.

The enforcement action we took:

Warning notice issued.