Care Quality Commission

Wirrelderly Limited

Elderholme Nursing Home

Inspection report

Clatterbridge Road
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Ratings

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

Overall summary

At our last inspection in May 2014, breaches of legal requirements were identified. We asked the provider to take appropriate action to ensure improvements were made. We undertook this comprehensive inspection on the 11 and 13 February 2015. During this visit we followed up the breaches identified during the May inspection and found the provider had not taken appropriate action in relation to people's care and welfare and how people's consent was sought prior to care being given.

Elderholme Nursing Home is single storey building set in the grounds of Clatterbridge Hospital. There are 61 single occupancy bedrooms. The home provides support for people with both nursing and personal care needs. The home also provides an intermediary care service. This means the home offers support to people discharged from hospital but who need a period of rehabilitation before they are ready to return home independently. There are 14 beds reserved for this purpose.

The registered manager of the home at the time of our inspection was on planned sick leave and did not participate in the inspection. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.'

During this inspection, we found breaches of Regulations 9,10, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9,17 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The majority of people felt safe living at the home and said staff treated them well. One person and one relative however reported that some staff had at times spoken to people in an inappropriate manner. We did not observe any inappropriate behaviour during our visit.

We found people's care plans did not cover all of people's needs and risks. Where risk assessments had been undertaken, risk assessment actions were not always acted upon to ensure people received the support they required and remained safe.

The provider's emergency procedures required improvement to ensure people were safely evacuated. People without accessible call bells in place had not had the individual risks associated with this, assessed properly and, where call bells where in place, sometimes the staff response to people's calls was not always prompt.

Where people had challenging behaviours, appropriate risk assessments had not been undertaken to ensure people were supported appropriately. Dementia care and person centred planning was poor and people's care plans lacked information on people's emotional and social needs. Where people had episodes of challenging behaviour or upset, care plans lacked information about how to alleviate their distress.

Some people who lived at the home had short term memory loss or dementia type conditions. People's capacity had not been assessed, they had not been supported to participate in decision making and best interest decisions had not been undertaken appropriately. Where people required the protection of a Deprivation of Liberty Safeguard (DoLS), there was no evidence of why it was required or any evidence that any least restrictive options had been explored.

The majority of people thought staff had the right skills and knowledge to care for them but relative's views were mixed. We looked at how the provider appraised, supervised and trained staff at the home. We found some gaps in the training of some staff members and found staff were supervised in groups.

The provider had a range of audits in place to check the quality of the service. Some of the systems however were ineffective. Care plans audits did not identify the gaps or inconsistencies in people's information or ensure risks were properly assessed and managed. Some of the actions identified in the weekly medication audit had not been acted upon and accident and incident audits were too brief to enable the provider to learn from and prevent similar accident/incidents occurring. The continuing breaches identified at the last inspection were also not picked up and addressed by the provider's quality management system.

People views were sought through the use of satisfaction surveys and resident meetings but none of the people we spoke with felt they had a say in the running of the service. Surveys were not analysed to enable the provider to come to an informed view of the quality of the service.

Staff were recruited in line with the provider's own recruitment policy and appropriate checks on their safety and suitability to work with vulnerable people had been completed prior to employment. The number of staff on duty was sufficient to meet people's needs. Staff we spoke with had an understanding of the care people required. They were also knowledgeable about types of potential abuse and what to do if they suspected abuse had occurred.

The home was clean, safe and well maintained. We saw that the provider had an infection control policy in place to minimise the spread of infection and a good supply of personal and protective equipment. For example, hand gels, disposable aprons and gloves. The home had recently been visited by Wirral NHS Infection Control Team and scored well in all areas.

The majority of people we spoke with at the home said they were well looked after and the staff were lovely. Most

Summary of findings

of the relatives we spoke with, confirmed this. We observed staff to be kind and respectful and the home provided a range of activities to occupy and interest people. This promoted their well-being.

People had access to sufficient quantities of nutritious food and drink and they were given a choice of menu options. Staff offered people support with their meals, assisted and encouraged people to eat when required. We observed a medication round and saw that it was administered to people in a safe way.

The people we spoke with had no complaints and were positive about the staff. One person and two relatives we spoke with had made complaints and were happy with the way they had been dealt with. Complaints records showed complaints had been responded to appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe and required improvement.

People's individual risks in the planning and delivery of care had not always been fully assessed and risk management actions not always carried out.

The provider's emergency procedures required improvement and did not ensure the safety of people in the event of an emergency situation.

People's call bells were not always answered promptly and some people who did not have call bells in place had not had the risks of this properly assessed.

Staff were recruited safely and there were sufficient staff on duty. Staff knew how to spot and respond to potential abuse.

Medication was safely administered and managed.

Is the service effective?

Inadequate

The service was not always effective.

Where people were identified as lacking capacity the principles of the Mental Capacity Act 2005 and DoLS legislation had not been followed to ensure people's consent was legally obtained and their human rights respected.

Records showed that some staff required training to ensure they were able to meet the needs of people who lived at the home. Staff had been supervised in groups but had not received individual supervision by their line manager.

People were given enough to eat and drink and were given a choice of suitable nutritious foods to meet their dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring and required improvement in some areas.

People and relatives said the staff were nice and treated them well. Staff were observed to be kind and respectful. Staff supported people at their own pace. Interactions between people and staff were positive.

Staff did not always explain before support was provided and one person's dignity needs had not been respected on the day of our visit.

People's independence was promoted and people were able to make everyday choices in how they lived their lives.

People were given appropriate information about the home. Regular residents meetings took place and but none of the people we spoke with felt they had a say in the running of the service.

Summary of findings

Is the service responsive?

Requires Improvement

The service was generally responsive but required improvement in some areas.

People's needs and care had been individually assessed, care planned and regularly reviewed.

People's care plans however did not cover person's emotional needs and risks. Information on how staff should respond and support people who displayed challenging behaviours or emotional distress was poor. This placed people at risk of inappropriate and unsafe care.

People's social needs were being met by a range of activities but sometimes people's consent to participate had not always been sought.

The majority of people and the relatives we spoke with had no complaints and were happy with the service provided. Complaints had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well led.

Some of the quality assurance systems in place did not effectively identify and address the risks to people's health, safety and welfare.

The breaches identified at the previous inspection in May 2014 had not been addressed through the provider's quality assurance systems and the provider's management of the service.

People's satisfaction with the service was sought through the use of satisfaction surveys. The results of these however had not been collated to enable the provider to come to an informed view of the quality of the service.

Elderholme Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 13 February 2015 and was unannounced. The inspection was carried out by three Adult Social Care (ASC) Inspectors, a Specialist Advisor in Mental Health and End of Life Care and an Expert by Experience. An Expert by Experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with 16 service users, eight relatives, the chief executive officer, the interim manager, the human resources manager, eight staff, two volunteer dignity champions and three healthcare professionals. We also spoke briefly to three students undertaking a work placement at the home. We reviewed a variety of records including eight care records, six staff records, a range of policies and procedures, two medication charts and a range of audits. After the inspection, we liaised with the NHS Infection Control team and the Local Authority.

We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms. We observed staff practice throughout our visit and used the Short Observation Framework Tool (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

After our inspection we asked the provider to send us additional information in relation to people's care, accidents and incidents, environmental audits, evacuation procedures, training and supervision information and a range of other policies and procedures. The provider responded promptly to these requests.

Requires Improvement

Is the service safe?

Our findings

We spoke with sixteen people who lived at the home and eight relatives. Most of the people told us they felt safe and were well looked after. Most of the relatives agreed with this. People's comments included "Oh yes, I'm safe, staff are good"; "Yes I'm safe, staff treat me very well"; "I'm very safe, they're good here" ; "Staff work very well and treat me well and "They treat me well most of the time".

One person told us that at times staff spoke to them in an inappropriate manner but did not wish to take the matter any further. A relative also told us they had overhead staff speaking to a person who lived at the home inappropriately. We observed staff throughout the day and did not see any inappropriate behaviour.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with five staff members who demonstrated an understanding of types of abuse and the action to take in the event that any potential abuse was suspected.

We reviewed eight people's care records. We saw some evidence that the risks in relation to people's health and welfare were assessed and regularly reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. We found however that not all of the risks in relation to people's care and safety were appropriately assessed and in some cases the risk management actions identified, had not been followed.

For example, two people's care records indicated that they were immobile, incontinent and at risk of pressure sores. The risk management actions identified to prevent pressure areas from developing, advised staff to regularly reposition the person and record the repositioning information. The interim manager told us that no repositioning charts or records were maintained. This meant there was no evidence that the person's risk management actions had been undertaken.

One person's pain assessment stated that staff should monitor and record the effectiveness of analgesia and review. One person's care plan and risk assessment of potential harm indicated they displayed challenging behaviour and a behaviour chart was to be put in place to monitor this. We found no evidence either of these actions had been done. We were told by members of the nursing team that there were no behavioural charts or pain management plans in place at the home. This meant the risks management actions identified were not implemented.

These examples demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people who lived at the home were not protected against the risks of receiving care that was inappropriate or unsafe as the planning and delivery of care did not meet all of the person's individual needs

We found plans and procedures for dealing with emergencies required some improvement. There were no individual emergency evacuation plans in place in any of eight care files we looked at. We asked the provider about this. We were provided with a copy of the Resident's Evacuation Procedure designed to identify each person, the room they lived in and the assistance they required in the event of an emergency. The information however was incomplete in respect of some people. For example, we were told there were 61 people who lived at the home, but there were only 58 people listed on the information. Details about the number of staff required to assist people was also missing for a significant number of people who lived at the home.

Some people at the home did not have accessible emergency call bells in place in their bedrooms. We asked the provider for evidence that the risks to people's safety had been assessed. We were given a copy of a generic risk assessment that stated people who did not have a call bell in place were incapable of using one. The people to whom this applied to were not identified, their individual risks were not considered and there was no adequate management plans in place to address any individual safety concerns.

We also found that staff did not always respond promptly when people's call bells were pressed. For example, at approximately 5.30pm on the first day we visited, we heard two people's call bells ringing in one of the wings. We went to investigate and found one gentleman with his door open in a state of undress and another lady requesting to go the toilet. There were no staff visible in the communal corridor. We went to find staff and found a staff member and student sitting in the communal lounge. We asked the staff member to respond to the call bells, which they did

Is the service safe?

straightaway. They told us they had not answered the call bells because they were completing people's daily charts. On the second day we visited, two call bells were ringing in another corridor for several minutes, there were three staff members in the communal corridor but no-one responded to the call bells. We shared our concerns with the interim manager about this.

These incidences were also breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation states that the provider must have procedures in place for dealing with and managing the risks to service users arising from emergency situations.

Accidents and incidents were recorded on a fall chart and used by staff to refer people to the Falls Prevention Team when required. People's falls were reviewed monthly and appropriate action was taken.

We did a tour of the building and saw that it was well maintained, clean and free from odours. There were 61 individual bedrooms all on the ground floor. The home was organised into five wings with two communal lounges. Most bedrooms did not have en-suite facilities. A communal toilet and a communal bathroom with specialised bathing facilities were available for people to use. One of the bathrooms contained four wheelchairs and a trolley housing personal and protective equipment. This made the bathroom cluttered and difficult to access. A poster on the wall advised staff that no more than two wheelchairs were to be stored in the bathroom at any one time. The visitor toilet also smelled of damp. We were told this would be looked at by the maintenance person on their return from annual leave.

The home's kitchen and onsite laundry were new and we saw evidence to indicate that both were well managed. The kitchen had been awarded a five star food hygiene rating from Environmental Health in October 2013 which meant food hygiene standards were rated as "very good". The laundry was well organised and adhered to Department of Health's infection control guidance in respect of the laundering of people's clothes and personal belongings.

There was a plentiful supply of personal and protective equipment such as aprons, disposable gloves and antibacterial hand gels throughout the home to prevent the spread of infection. The NHS Infection Control team had carried out a visit in November 2014 and scored the provider well in all areas of infection control.

Recruitment policies were in place for the safe recruitment of staff. We looked at the personnel records for six staff members and saw that they were recruited in accordance with the policy. Two staff files we looked at related to nursing staff and we saw evidence that their professional registration with the Nursing and Midwifery Council had been checked and was up to date. We were also shown evidence that persons employed were subject to criminal record checks by the provider. This showed us that appropriate employment checks were carried out to ensure staff were safe and suitable to work with vulnerable people prior to employment.

We checked the staffing rotas. Rota arrangements were planned sufficiently in advance and showed adequate numbers of staff on duty. Most people said there were enough staff on duty to meet their needs. We observed staffing levels to be sufficient on the days we visited. Some people and relatives commented however on the movement of staff across the home to work on different wings. We asked the interim manager about this. They told us that half the staff team working on each wing, moved to another wing every six months. We discussed the impact this may have on people with dementia type conditions who may rely on the continuity of the staff in the delivery of care to feel safe at the home.

All of the people we spoke with confirmed they received their medication at the right time. We saw that people's medication was kept in a locked trolley which was stored in a locked room. Controlled drugs were also stored securely. On the second day we visited however, the medication trolley was left open and unattended in a communal corridor during the medication round. This meant there was a risk of unauthorised use as medication was accessible to people who lived at the home, staff and visitors. We observed a medication round in progress. We saw that medicines were administered in a safe way.

Inadequate

Is the service effective?

Our findings

People's feedback about the skills and knowledge of staff at the home was positive. Comments included "Yes, they (the staff) are all very good"; "When they use the hoist they know what they're doing. They're very patient"; They ask do you want help and what can we do"; "I must confess I have no complaints the staff are very good. I would recommend the place to anyone" and "If you ask for anything to be done, it's done, they are so good". We spoke with a visiting healthcare worker who also spoke positively about the home.

Relatives had mixed responses with regards to staff skills and knowledge. Positive comments included "We think the staff are skilled and open to learning. We trust the staff" and I feel that the standards seem to be very good". Other comments included "Some have, some have not" and "Most do, some don't. Sometimes their communication is not good".

We spoke with the interim manager and five staff about the people they cared for. We observed staff supporting people throughout the day and from our observations it was clear staff had good relations with the people they cared for. Staff we spoke with had knowledge of people's needs. Care staff however told us that they were not expected to read everyone's care plans.

We viewed the care records of eight people with dementia type conditions and/or complex needs. We found that the provider had not complied with the requirements of the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS). They also did not comply with this legislation at their previous inspection in May 2014. This meant people's legal rights in relation to consent were not respected or their human rights protected.

Six people were described as lacking capacity in the care files we looked at. In all the files we looked at, where people had been described as lacking capacity, there was no evidence that any assessment of the person's capacity had been undertaken in relation to decisions made about their care. There was no evidence of best interest decision making and no evidence that everything practicable had been done to support the person to make their own decisions about the care they wanted to receive. This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected.

We saw that where people were described as lacking capacity, consent for the taking and use of their image for photographs, the taking of people's weights in the delivery of care, having their bedroom door open, the use of bed rails and the administration of medication by staff, had in the majority, been given by people's relatives.

The Mental Capacity Acts 2005 (MCA) states that relatives cannot be asked to sign consent forms when a person lacks capacity unless they have authority to do so under a Lasting Power of Attorney or a Court Appointed Deputy. Of the six files we looked at where people were identified as lacking capacity, only two people had either of these authorised persons in place. One person had a Lasting Power of Attorney in place but there was no information as to who they were or what decisions they were able to make. One person had a Court Appointed Deputy in place but there was no information as to who this Court Appointed Deputy was.

We saw in one person's file, that the person's relative had requested that the person's medication be given covertly. The covert administration of medication means that the person's medication is likely to be crushed in the person's food or drink without their knowledge. When making decisions about covert administration, the MCA states that a best interest meeting must take place with other professionals involved in the person's care and where appropriate family members with the discussion recorded. There was no evidence of this.

Four people's care records indicated that the provider had applied to the Local Authority for a DoLS for aspects of their care. There were no records kept as to why an application had been submitted, no evidence that any least restrictive options had been explored, no evidence of best interest decision making and no evidence that the DoLS had been authorised by the Local Authority. In one person's case, we saw that all staff had been instructed to deprive the person of their liberty despite the person's DoLS not being authorised.

These incidences were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 11 of the Health and

Inadequate

Is the service effective?

Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We spoke to the Chief Executive Officer and the interim manager about the issues we had identified. Neither demonstrated that they had a sufficient knowledge or understanding of MCA or DoLS legislation. After our inspection, the issues we identified were referred to the safeguarding team at the local authority to investigate.

We reviewed six personnel files in relation to staff employed and saw evidence staff had received an induction when they first started working at the home. Staff we spoke with told us they felt supported in their job role.

We asked the interim manager and the human resources manager for evidence that staff received appropriate appraisal and supervision. The human resources manager told us that staff appraisals took place at the same time each year in September and we were shown a sample of three completed appraisal forms. We asked to see a list of the dates by which each staff member had been appraised. We were told that as appraisals took place the same time each year, no list was maintained.

The provider's supervision policy stated staff supervision was used to monitor and review staff member's work and to provide constructive feedback on their progress. It specified that all formal supervision sessions were to be recorded, dated, signed and retained by management. We did not find evidence this was the case.

We asked to see evidence that staff had access to supervision. We were told by the Human Resources manager that staff attended group supervision. We were given copies of staff signing in sheets called "Care Assistant Training Sessions". These sheets indicated staff had received group training in topics such as independence and dependence and urinary tract infections. We expressed some concerns that staff did not receive individual supervision sessions with their line manager.

We asked the interim manager about staff training. We were shown a training checklist that demonstrated staff were offered training in a wide range of health and social care topics. For example, we saw that the majority of staff had completed training in basic food hygiene, safeguarding, accident procedure, infection control, fire evacuation, manual handling, food fortification and nutrition. However we did note some training was still required for some staff in challenging behaviour and mental capacity training.

We saw that there was training for nursing staff in catheter care, syringe driver theory and diabetes. Some of the dates recorded on the training checklist however were over two years old. This meant there was a risk staff skills and knowledge could be out of date.

The home itself did not provide a dementia friendly environment. For example, signage throughout the building was small and above eye level, all of the bedrooms looked the same and environmental cues which help people with dementia to orientate themselves to their surroundings were poor. There was also no difference in colour or design between people's personal bedroom doors or bathroom doors to enable people with dementia to tell the difference. We spoke to the human resources and interim manager about this who told us the provider had plans in place to review this.

People told us the food at the home was good. Their comments included "Exceptionally good. It's good quality"; "Very well cooked"; It's very good but too much"; "The food is always wonderful"; "Generally the food is very good indeed" and "The foods quite good but not much choice. If I don't like something I don't eat it. I've not thought of asking for something else".

Two relatives we spoke with expressed concerns with regards to the person's nutritional care. One relative said that although staff ensured the person had sufficient drinks they did not think staff "Prompted them enough to drink especially as they had suffered a water infection". Another relative told us that they and the person who lived at the home had not been happy with aspects of their nutritional care. They said they discussed it with staff and that they were eventually listened to.

We observed the serving of the lunchtime meal. We saw that the lunch menu was displayed on various notice boards throughout the home. Each dining room was light, airy and dining room tables were nicely decorated. We saw that there were two choices on offer for lunch on the day of our visit, roast dinner with lamb or chicken fillet, followed by lemon meringue pie.

We saw that staff told people what the meal choices were and asked what they would prefer prior to serving. People's

Inadequate

Is the service effective?

meals were served promptly and pleasantly. People were offered suitable and sufficient quantities of both food and drink. Where people required support to eat, staff supported people in a friendly and unrushed manner and gently encouraged them with their meals.

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Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with described the care they received as good or very good. People's comments included staff are "All very good"; "All them are (caring). It's a hard job for them"; "Staff treat me well. They have time for a chat. They say it's part of their role"; "I think the care is good or very good. No complaints"; "The care is excellent and meets my needs"; "The care is generally good. It's just like a hotel" and "It's very nice here".

Relatives views of the care provided were however mixed. Positive comments included "Staff are very friendly and helpful and look after mum well"; " Staff treat them very well"; "Give them a good report they deserve it"; "Everyone is so lovely. They love my mum"; "I am absolutely delighted, can't fault them". Any problems they are immediately on the phone" and "Staff are absolutely lovely".

Whilst other relative comments included "There are a few weaknesses. Sometimes I come in and their top is wet or food is on their clothes and staff don't seem to have bothered cleaning them up after they have eaten. Sometimes they haven't been shaved. Most staff are caring and treat them well generally but sometimes they seem to treat them like a baby" and "Some staff are caring"

We observed staff throughout the day interacting with people who lived at the home and saw that they were respectful, pleasant and patient. We observed the lunchtime period. As some people had communication difficulties due to declining mental health, we completed a Short Observation Framework for Inspection Tool (SOFI) in one of the communal lunch rooms. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Using the SOFI, we saw that the majority of staff interactions with people were positive. We observed staff asking people if they had enjoyed their meals, offering to assist them with their food and having a laugh and a joke with people.

We noted that some but not all staff spoke to people before providing support and assistance. For example, one person's hands and face were wiped without asking and had their legs lifted onto the footplates of their wheelchair without warning. We also saw that one a person was taken to the dining room with one slipper on and one slipper off, which compromised their dignity. A relative we spoke with during our visit, fed back that "Some staff explain and let them (the person) absorb the information when they are helping them (the person), but not all. They (the person) gets upset if they don't".

Staff we spoke with gave clear examples of how they protected people's privacy and dignity in the delivery of personal care. One person and one relative we spoke with however expressed concerns about the home's open door policy which meant that the home preferred people to have their bedroom door open during the day. The person told us "One thing I don't like is they want the doors open when you are sitting reading, I feel I am on show. People walk past and look in. I'm sure they have a reason for leaving it open but I don't like it, I shall close it later. A relative said "They (the person) like the door closed but this doesn't always happen".

We asked the interim manager about this. They told us and we saw in people's care records that consent to have the door open had been given in the majority by people's relatives. There was little evidence that this decision had been discussed with people who lived at the home to ensure they were comfortable with this arrangement.

We discussed the open door policy with the home's volunteer dignity champion. We were told that in general people enjoyed being able to see and hear activity in the corridors and as a result did not feel so isolated. They said however that they were going to raise the issue of door being left open during the delivery of care or whilst people had visitors.

We saw that care plans included a dependency assessment which contained information in relation to what people could do independently and what they needed help with in relation to their mobility and personal care. We saw that people were provided with mobility aids to enable them to be independently mobile and adaptive crockery was provided to enable people with dexterity difficulties to eat independently. We also saw that people's end of life decisions were noted in care files, but in some instances where people had been identified as lacking capacity, their end of life care had been discussed and decided upon by the person's relative. There was little evidence that the person's ability to make these decisions for themselves was assessed or enabled.

Requires Improvement

Is the service caring?

We reviewed the provider's service user guide. The guide described the home, outlined the home's fees and the service provided. We also saw that the provider produced a monthly newsletter that contained information relating to the activities on offer, up and coming events and the provider's complaints procedure. This demonstrated that people were given appropriate information in relation to their care and treatment.

Two people told us a resident meeting took place every few months and we saw evidence that confirmed this. None of the people we spoke with however felt they had a say in the running of the service.

Requires Improvement

Is the service responsive?

Our findings

The majority of people and relatives we spoke with had no complaints or concerns about the care they received. One relative said "Any problems, just go to the key nurse and they are here".

People we spoke with said they had prompt access to medical and other healthcare support as and when needed. Relatives also confirmed this. This indicated that the service responded appropriately to people's medical and physical health related needs.

Each person's care file contained an assessment and care plan. Assessment and care planning information identified people's needs and the care they required. For example, an assessment of people's dexterity, mobility, eating and drinking continence, personal care requirements and sociability were all undertaken.

We saw that care plans contained some information in relation to people preferences for example, what time people like to go to bed, what drinks they preferred and what social activities they liked for example, reading books or watching certain movies on the television. We saw however that this information was in some people's care plans but not others. This meant some of the information critical to the provision of person centred care was missing for some people.

Three of the seven care records we looked at contained people's life histories. This information was brief but gave staff a basic insight into the person's life prior to admission to the home for example, education, employment and family life. There was very little information however of personal or life history information in the other four files we looked at. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

We found that overall dementia care planning and the person centred planning for people's emotional needs and risks required some improvement. Where people had emotional needs or behaviours that challenged, there was no evidence they had been risk assessed and appropriate support planned. There were no behavioural charts in place to monitor people's challenging behaviours and care plans held no information about the frequency, intensity or triggers to these behaviours in order to assist with their management. There was no guidance to staff on how best to support the person when these behaviours were displayed. These concern were raised with the provider at our last visit.

For example, we saw a mental health professional had advised staff to develop an appropriate communication system with one person who displayed challenging behaviours. They advised the provider that this would help the person communicate their needs and reduce the occurrence of any unwanted behaviours. We saw that this advice was given to provider some time ago. There was no evidence however that a communication system had been developed in accordance with this advice. We asked the interim manager about this who told us that no documented communication system was in place and asked us what the doctor had meant. We also saw that there was no evidence in the person's care file to indicate staff had learnt from unwanted incidents or revisited their approach to the management of these incidents in order to support the person. The person's daily notes showed they continued to have episodes of distress and challenging behaviours. This meant the provider had not explored or responded to the potential causes of this person's distress or ensured their ability to communicate was facilitated.

One person was described as prone to occasional physical aggression and episodes of distress. There was no evidence that the cause of the person's distress had been explored and no guidance was given to staff on how to alleviate the person's distress when they became upset. The person's daily notes indicated they continued to be unsettled and prone to emotional upset.

These incidences were also a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not responded to people's emotional needs in order to ensure their welfare and safety.

The home employed an activities co-ordinator who provided a range of social activities each day. These activities were advised on noticeboards throughout the home. For example, there was a book club, nail care and make up sessions, board games, exercise class and

Requires Improvement

Is the service responsive?

remembrance activities. On the day of our visit, there were a small number of students from a local college undertaking nail painting with four people in this lounge in front of other people. The students we observed were kind and gentle but three of the people they were trying to assist had communication difficulties, did not respond verbally to the students in any way and appear confused.

We saw in one of the care files we looked at, that the person had communication difficulties. The person's care plans stated they were to attend daily activities. We asked the nurse on duty how they knew the person wanted to go to activities if they had difficulty communicating. They replied “We don’t”.

The seating in one of the communal lounges was arranged around the room. We saw that this lounge was used as a passageway for staff, visitors and people who lived at the home to access other areas of the building. This arrangement was not very sociable and we saw that the passage of traffic through the lounge disrupted some people’s view of the television.

One person we spoke with told us that they had previously made a complaint. They told us that they were pleased with the way the complaint was dealt with and satisfied with the outcome.

We spoke to a relative who had also made a formal complaint and they too were happy with the outcome. The complaint they had made was recorded in the complaints file and there was evidence to indicate the complaint had been appropriately addressed.

The provider had a complaints policy in place and a recent survey undertaken by people at the home and their relatives showed that people knew how to make a complaint. Complaint records maintained by the provider showed appropriate action had been taken. There was also a suggestions box on a wall in the reception area. We reviewed the provider’s compliments file and saw that numerous thank-you cards and letters had been received by the home.

Requires Improvement

Is the service well-led?

Our findings

People thought the service was well managed. When we asked relatives, however their responses were mixed. Positive relative comments included "The manager is always around. Runs a tight ship. Nothing gets past them. They do their job well, doesn't stand for any messing"; "The manager is very visible, very motivational and has high standards" and "The home does run really well".

One relative however said "The management could be a bit tighter and have a tighter hold on what's happening", another relative said "I don't think the care workers are supervised very well".

The breaches identified at the provider's previous inspection in May 2014 had not been responded to, to ensure the running of the service complied with the Health and Social Care Act, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The management team needed to make further improvements to ensure that people's needs were met safely and appropriately.

We saw that the provider undertook a range of regular audits to monitor the quality and safety of the service provided. This included an audit of care plans, health and safety, environmental audits, hand hygiene audits, equipment audits, accident and incident audits and medication audits. Some of the audits however were ineffective.

There were a number of inconsistences in people's care records about their needs and risks and information about people's preferences and wishes had not always been completed. For example, one person's mobility risk assessment for February 2015 stated the person was mobile with the assistance of a mobility aid and two staff but their moving and handling risk assessment said the person was immobile and unable to sit or stand.

Another person's pre admission assessment in February 2015 stated they were hard of hearing but their eyesight was very good. Their dependency assessment however noted the person's hearing was very good and their mobility care plan stated their eyesight was poor.

This meant that the provider's care plan audits failed to be effective in ensuring the information about people's needs and preferences was correct and complete.

An audit of the medication system was undertaken weekly. All but one of the weekly audits from the 8th January 2015 identified that no dates had been recorded for when medications had been delivered from the pharmacy and booked in by the home. The audits stated that repeated emails had been sent to staff to request this to be done. Despite this, the same issue was identified on subsequent audits. This meant the audit failed to ensure effective action was taken.

Accidents and incident records were too brief and there was no evidence that the provider audited these records with a view to pinpoint any patterns in when or how people fell in order that preventative action could be taken at an organisational level. This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

We were handed a large file of individual surveys that people and their relatives had completed. For example there was evidence of a social interaction survey, a dignity survey and abuse awareness survey. There was no evidence however that that the results of the surveys had been collated to enable the provider to come to an informed view of service. Individual surveys were also not always dated. This meant it was impossible to tell if people's opinions had been surveyed recently.

These incidences were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to identify, assess and manage the risks relating to the health, welfare and safety of people at the home.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who lived at the home were not protected against the risks of receiving inappropriate or unsafe care because the planning and delivery of care did not meet all of the person's individual needs and risks. Regulation 9(1)(b)(i)(ii) and 9(2) of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 9(1)(a) and(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision There were no effective systems in place to identify, assess and manage the risks to people's health, welfare and safety. Regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17(1)(a),b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider failed to have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010 corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.