Larchwood Care Homes (North) Limited

Appleby

Inspection report

Military Road
North Shields
Tyne and Wear
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 August 2018 and was unannounced. A second day of inspection took place on 14 August 2018 which was announced.

Appleby is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Appleby is registered to accommodate 55 people in one adapted building across two floors. At the time of the inspection we were informed that refurbishments had taken place and Appleby could now only accommodate 50 people. We had not been notified of this change in registration. At the time of the inspection 42 people were resident. The first floor specialises in providing care to men living with a dementia who may, at times, be anxious and distressed.

The service had a registered manager who had been in post on a full-time basis since February 2018. They were registered with the Commission on 7 August 2018. 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.

During this inspection we found breaches of regulation in relation to consent and good governance. Mental capacity assessments and best interest decisions had been completed however some were over a year old and had not been reviewed. For some people who lacked capacity their safety was maintained through the use of restrictive equipment such as bed rails and wheelchair lap belts but there was no recorded capacity assessment or best interest decision.

The quality assurance processes had not been sufficiently embedded to identity all the areas for improvement noted during the inspection.

Some care plans lacked detail whilst others were person centred and thorough. Some risks to people had not been assessed and some risk assessments were over a year old. Reviews of risk assessments lacked detail.

The quality of recording of medicines, in particular as and when required medicines and the application of prescribed creams varied. We did not find any people had come to any harm due to the administration of medicines and by the second day of inspection a fully audit had been completed, improvements made and an action plan implemented to ensure sustainability.

Staff were kind and caring in their approach and we observed genuinely warm relationships between people and staff. People told us they were treated with dignity and respect.

Staff understood safeguarding procedures and were confident to report any concerns.

Accidents, incidents and safeguarding concerns were analysed for trends and lessons learnt. Some practices had been amended in response to this analysis.

Concerns and complaints were logged, investigated and responded to. People and their relatives confirmed they had no reason to complain but were confident any concerns would be addressed.

Staff levels were assessed using a dependency tool and there were sufficient staff to meet people's needs. Safe recruitment practices were in place.

The registered manager ensured staff were well supported, including the provision of formal supervision meetings and an annual appraisal. Staff new in post had their performance and support reviewed in probation meetings.

Training was provided and staff had the opportunity to develop their skills so they could support the nurses with evaluations and some clinical 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.

People's nutrition and hydration needs were met and they were supported to access healthcare professionals, such as speech and language therapy and the behaviour team as well as general practitioners.

Quality assurance and governance systems were in place and had identified some areas for improvement. Comments from staff were that the registered manager had made improvements since being in post and the morale of the team had lifted.

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

Requires Improvement

The service was not consistently safe.

The quality of the recording of medicines varied. Immediate steps were taken to implement improvements.

Risk assessments were in place but not always sufficiently detailed or up to date.

Staff understood safeguarding procedures and analyses of incidents had led to improvements and lessons being learnt.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments and best interest decision were not always completed and not always reviewed.

Staff were trained and there was the opportunity for care staff to develop some clinical skills to support the nursing staff.

Peoples nutrition and hydration needs were met and external healthcare professionals were involved in people's care.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were treated with kindness and respect.

People and relatives were involved in decision making about care and support.

Privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

The content and quality of care records varied, a plan was in

place to ensure improvements were made.

Concerns and complaints were logged, investigated and responded to.

It was important to staff that people's wishes were respected at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance systems had not been effective in identifying the areas for improvement found during the inspection.

Improvements needed to medicines management had been identified but had not been acted upon.

There was evidence of lessons learnt and some improvements had been made.

Appleby

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 9 August 2018 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 14 August 2018 which was announced.

The inspection team was made up of one adult social care inspector, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority commissioning team, CCG and the safeguarding adult's team. We also contacted healthcare professionals whom the registered manager identified as key stakeholders and the local fire service. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the service and nine relatives. We spent time with people in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the deputy manager who was a nurse, and the regional manager. We also spoke with seven members of the care team including, a senior, a team leader care staff and activities co-ordinator. We also spoke with ancillary staff including the chef, admin staff, domestic staff, laundry and

maintenance.

We looked at care records for seven people, medicines records for five people and cream application records for 11 people. We reviewed supervision and training records and recruitment information for three staff. We also reviewed records relating to the management of the service.

We looked around the building and spent time in the communal areas.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were in place but not always recorded in sufficient depth to show they were up to date or had fully considered all risks. For example: one person with epilepsy had a risk assessment but it contained vague control measures such as keeping the person safe during a seizure. The person's mobility and general safety care plan identified measures to keep the person safe. Some people had risk assessments that were dated from 2016, for example, one person had a choking and aspiration risk assessment dated 25 April 2016, another person's was dated 4 December 2015. Evaluations had been completed but they often lacked detail of how it had been assessed that the control measures remained relevant.

The quality of records relating to medicines management varied across the two floors. On the first-floor there was inconsistent recording of when people refused to take their medicines. The providers policy stated refusals must be documented on the reverse of the medicine administration record (MAR).

Topical Medicines Administration Records (TMAR) were in place to guide staff on the application of prescribed creams however records were not always clear. For example, one cream had not been applied on 23 days over the last month despite it being prescribed to be applied twice daily. There was a high level of stock of some topical medicines with eight tubes of cream found for one person who was no longer prescribed this item.

Some medicines were applied using a patch. The application record form for one person was faded and it was not clear if staff were signing to say a patch had been applied or removed. It was identified by an 'x' where staff had applied the patch and it looked like patches were being applied on the same site. Manufacturer's guidelines for this medicine is that patches can be applied on the same limb but should not be placed on the same site within a 14-day period. The registered manager sought advice on this from the manufacturer following day one of the inspection and has ensured specific instructions are in place so the patches are not applied on the same site.

Protocols were in place for the administration of when required medicines. On the ground floor the information was generalised and not person specific. For example, one person was prescribed a medicine for pain relief and guidance stated, 'to be given when shows signs of pain' yet there was no guidance to support staff on what these signs were which may differ for individuals.

Some people received their medicines covertly, that is, disguised in food or drink when a person lacks mental capacity. On the ground floor the home's policy and mental capacity act guidance was followed to ensure all paperwork was in place. However, for one person no advice had been sought from a pharmacist to advise the home on how these medicines could be given safely. We spoke with the registered manager and deputy manager about this who advised that the person was not actually receiving their medicines covertly. By day two of the inspection the deputy manager had contacted the person's doctor to have their medicines reviewed.

On day two of the inspection the deputy manager said, "A full audit of creams has been done and daily

checks are now in place." They had completed an action plan in relation to medicines and we saw improvements had been made. The procedures for the application of creams had been revised so nursing staff were responsible for any medicated creams and the times creams should be applied were being recorded on the TMARs. Care plans and systems for the administration of covert medicines had been renewed and protocols for when required medicines were to be rewritten. Audit systems for ensuring the new processes were embedded into daily practice had also been introduced and medicines management had been added to the home development plan.

Medicines were stored securely and safely. Temperature checks of the medicines fridge and treatment room were completed so medicines were stored at the correct temperatures. Controlled medicines, that is, medicines that require extra checks and special storage arrangements because of their potential for misuse, were appropriately stored and signed for when they were administered. Some people we spoke with told us they were happy with how their medicines were administered. Comments included, "I get my medication and all is fine," and "I get my medication twice a day and have no problems." Relative's also shared this view saying, "My [family member] receives their medication morning and evening and everything seems to working. I've no complaints" and "The nurses are great, they make sure my [family member] gets the right medication."

People and their relatives told us they thought Appleby was a safe place to live. One person told us, "I'm safe and well cared for." Another said, "I do feel safe in here, because there are people around if I need anything." Other comments included, "I feel very safe in here, I am not on my own and I always have help" and "I feel safe yes, not had any reason not to." Relatives said, "I have peace of mind [family member] is safe. I feel confident leaving them here," "It's very safe in here. I never worry about my [family member]," and "I feel my [family member] is totally safe and well looked after."

Safeguarding concerns were logged and alerted to the appropriate authorities. Accidents and incidents were also logged. Analyses of all incidents and concerns were completed and lessons had been learnt, such as identifying the times most incidents had occurred. This had led to increased activities and a change to staff deployment which had seen a reduction in the number of occurrences at these times. A staff member said, "It's about abuse, it could be anything from alcohol use to not taking care of positional changes and pressure care. I would flag it to the nurse and the manager and write a statement. If they didn't take it seriously enough I would take it higher but I think they would."

Premises safety was managed appropriately. The registered manager said the fire service had inspected recently. New signage had been fitted in the loft and a fridge freezer had been moved to ensure it wasn't obstructing a fire exit. Personal emergency evacuation plans were in place, some of which needed to be reviewed, and regular fire drills had been completed with all staff. Staff understood the actions they needed to take if the alarms sounded. This included the safe evacuation of people to the next fire compartment.

Some areas of the home were incredibly warm with little ventilation. This was incredibly pertinent given the recent heatwave. Action had been taken by way of keeping curtains closed to stop the direct impact on the sun, opening windows and supporting people to move to cooler areas of the home. In addition, portable air conditioning units had been purchased and cooled drinks were available and encouraged. The registered manager had raised ventilation with the providers who were assessing the situation to see how this could be improved.

Necessary checks of fire doors, bed rails and window restrictors were completed by the maintenance person in addition to contractors servicing of equipment. A landlord's gas safety certificate and electrical installation condition report were in place.

The first floor of Appleby was a specialised unit for men who displayed high levels of distressed and anxious behaviour. The PINCH ME approach to supporting people was used. This approach has several steps including the management and/or treatment of P= pain and psychiatric disorder, I=Infection, N=Nutrition, C=Constipation, M=Medicines and metabolic state and E=Environmental factors. One staff member said, "The training was really good and interesting. We did activities to make us feel how residents might feel. It makes you see things from a different way so you're aware of the sensory needs of people."

The registered manager said, "We have changed the approach to staffing and have one staff in each communal room and one watching the corridors." They also explained that the décor had been improved to include visual aids and specific sensory areas such as a train station, bar area, 'man shed' and forest area. This deployment of staff and improvements to the environment had led to a reduced number of altercations between people as staff were more confident in supporting people appropriately and were able to identify triggers earlier and distract people.

Peoples needs were attended to in a timely manner. The deputy manager, who was also the clinical lead was based on the ground floor of the home and a nurse unit manager had just been recruited to manage the first floor. There were some specific staff working on each floor which meant people had familiar staff who knew them well. During the day each floor was staffed with a nurse, a senior or team leader and three care staff. We were told this was enough. One staff member said, "It can be hard but we make it work, the senior will help and the nurse if we need them to."

A dependency tool was used to calculate the level of staffing needed and rotas reflected the required level of staffing. Everyone we spoke with said they thought there was enough staff most of the time. On busier days staff said they could manage. The kitchen staff thought it would be of benefit to have another staff member but said it was manageable at the present time.

Recruitment was managed by the admin staff who said, "We would do the DBS application and get the references, if people don't have a previous employer we would ask for three other reference and verify them." Disclosure and Barring service checks are used to enable employers to identify people with a criminal record and make appropriate decisions to ensure only suitable people are employed to work with vulnerable adults and children. DBS checks were renewed on a three-yearly basis and Nursing and Midwifery Council checks (NMC) of nurse PIN numbers were completed monthly.

Audits were completed of the competence and cleanliness of the premises and equipment used. This included the cleaning of mattresses and beds. Commodes were not used in the home which the registered manager was proud of. They explained each bedroom was ensuite and people had access to several toilets on each floor which meant continence needs were well catered for.

A member of the domestic team said, "I have a good induction with [registered manager] and [deputy manager]. We have access to all the products we need and the equipment." Some areas of the home did have a slight malodour. The registered manager explained that the flooring in some areas hadn't been sealed correctly which was causing this. They added that it was being looked into and if it couldn't be resolved a new floor would be put down.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications and authorisations were in place and the registered manager said any conditions on authorisations were being met.

Staff understood that some people lacked the capacity to make some decisions so it was their role to support people to be involved in discussions and to make decisions which were in people's best interest. Staff said, "Mental capacity is about people making their own decisions, if we make decisions for people it needs to be the right decision so not giving a vegetarian meat as that would be against equality and religion." Mental capacity assessments and best interest decisions had been documented however some had not been reviewed since being written and were over 12 months old. We also saw some people who used bed rails and wheel chair lap belts so were restricted for their own safety, did not have capacity assessments of best interest decisions in place.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Need for Consent.

Plans were in place to upskill some of the care staff so they were able to support the nursing staff with some clinical care. This included areas such as PEG care and MUST. PEG is a feeding tube which goes directly into a person's stomach and MUST is a nationally recognised screening tool for malnutrition. React to Red training had also been rolled out which is about skin integrity and the prevention and management of pressure sores.

One staff member said, "Training is great, we're always asked if there's extra we want. I like to learn as much as possible." A training matrix was in place which evidenced staff had attended training in safeguarding, moving and handling and positive behaviour support. A training plan was in place to ensure everyone attended training as required, Some training deemed non-mandatory was being provided and included some clinical skills as well as additional training on nutrition and hydration.

Initial supervision meetings had been led by the registered manager so they could get to know the staff team. They said, "I did the first two supervisions to get to know people but I'm handing over to the nurses

and seniors now." A planner was in place so everyone knew when supervisions and appraisals were scheduled to take place. One staff member said, "Supervision is helpful, it's an 'in confidence' meeting so it's good to get things off your chest. I had an appraisal with [registered manager]. They are good, good with the residents and you can have a laugh. They are easy to talk to if you have any concerns, I'm confident they would act on things if I needed them to."

Systems were in place to ensure the team worked well together, and with any healthcare professionals involved in people's care. One staff member said, "We have fantastic night staff who get on great with the day staff, everyone is approachable and our priority are the residents." Another staff member said, "The night nurse is supportive, any problems we solve them together." They added, "There's a good staff mix so it depends on that were you work, if you're newer you work downstairs." One staff member said, "My induction was enough but I could have done with a shadowing day upstairs as it's very different to downstairs."

People's needs and choices were assessed with input from any members of the multi-disciplinary team involved in people's care. Pre-admission assessments were completed and an admission process was in place which included ensuring a medicine handover was completed and that the person's room and any equipment was in place and fit for purpose.

The morning handover was detailed and informative. Each person was mentioned and an update given on how they were, their dietary needs and medicines. If someone wasn't themselves it was mentioned if their doctor was contacted, or whether the nurse felt staff needed to keep a closer eye on the person. People who were having a birthday were also mentioned and day staff were reminded to ask the kitchen to make a birthday cake for someone.

The chef was knowledgeable about people's dietary needs. They said, "The nurses share information about people and their needs, their likes and dislikes, portion sizes and allergies. We are told about any weight loss and fortifying meals, it's pretty good." They were aware of the involvement of the speech and language therapy team and knew who needed soft or pureed meals. They said, "I don't like moulding foods as you need to make it the day before, freeze it and reheat it so I make it on the day and puree everything separately for people."

There were no people with any cultural needs in relation to their diet but the chef said, "I can get Halal meat and the second option is always vegetarian." The food was fresh and everyone seemed to enjoy their meals. For people who did not want the main meal or weren't hungry they were offered alternatives, such as sandwiches. One person said, "I really like the food here, we are well looked after. There is always plenty to eat and drink if you want it, as long as I get eggs in the morning I'm happy." Another person said, "We are well fed and watered here, I have no complaints."

Healthcare professionals were involved in people's lives. The deputy manager said, "The GP visits every Wednesday so we have a system in place to identify those people the GP needs to see. I send a weekly update with any concerns, medicines reviews that are due and any reviews that are needed to health care plans or do not attempt cardio pulmonary resuscitation." Records evidenced that people had involvement from the dietician, speech and language therapy and district nurses.

Areas of the home had been decorated to provide sensory stimulation based on specific themes. For example, on the first floor there was a station area complete with sound effects and visual stimuli of trains. There was also an area dedicated to 'men at work' which included roadwork signs, and plumbing equipment such as pipes and stopcocks for the men to use. Downstairs there was a sweet shop area and access to the garden.

The registered manager said, "We've redone all the home to make it dementia friendly. We have music in the corridors and visual aids. There is ongoing work in the garden it's secure." The maintenance person said they had plans to develop a sensory garden for people and had already developed specific areas including a beach area, 'man shed,' ice cream parlour and stream with water feature. They explained risk assessments had been completed. They said, "I love doing things for the residents, it needs to be a safe place for people, staff and visitors."

Dementia friendly signage was used to support people to find their way around the home and all toilets had toilet seats of a contrasting colour. Memory boxes had been used to support sensory involvement and reminiscence however the registered manager explained these had not worked for people so areas of the home were dedicated to reminiscence in relation to old photographs or objects of interest to people.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received. One person said, "The staff are lovely, they will always help you if they can." Another person said, "They are very kind and do what they can to help you." A third person said, "It's lovely here. This is a lovely venue, the girls are lovely, they look after me well." A relative said, "I'm very impressed, it's like a second home. [Family member] is well looked after and I'm very grateful. They do all you would expect." They added, "Everyone is very nice with [family member]."

Relatives were complimentary of the care provided. We were told, "The staff all do a great job here. I feel they get the TLC (tender loving care) that they need and I can't ask for any more than that really." Another relative said, "The staff here are really nice. I feel [family member] is looked after well." Relatives also said they were involved in the decision-making process about their family members care. One relative said, "Staff are great and they always call and let us know if there are any changes to discuss."

People also said their privacy and dignity was respected. They said if they need support, especially with personal care or bathing they were respected and advised curtains were always pulled and doors closed for privacy and dignity. Interactions were appropriate and discrete support was offered to people to maintain their dignity and show respect.

People said their choices were respected and commented that they could go to bed and get up whenever they wanted to. People said, "I like to go to bed by 7pm" and another person said, "I don't sleep that well and I like to go (to bed) around 9pm."

We spent time in the communal areas with people and observed how people were treated. Staff had a relaxed and caring relationship with people and relatives. There was lots of engagement and laughter. Some people were seen having a joke with staff or just sitting with a staff member holding their hand having a quiet conversation. If people were repetitive in their conversations staff were patient and responded to the person as though they had only asked the question once. Explanations and reassurances were offered to people. One staff member said, "We know people so well that we know how to respond, I wouldn't be so detailed in response to other people but I know [person] understands if we explain things like that. For other people it would be distressing to be reminded so we wouldn't do it."

If people needed one to one support this was provided appropriately, with staff working together to ensure the support received was consistent and maintained. Some people were offered physical support with their meals such as hand on hand support, whilst for other people staff asked if they would like someone to cut their food for them. Regardless of the level of peoples' needs they were treated respectfully and with dignity.

A relative said, "There are resident meetings we can go to if we want." Minutes of relatives meetings were in place and included updates on health and safety, training, activities and menus. There was time given to relatives so they could raise any issues. This included comments that promises had been made in the past and nothing seemed to happen. The registered manager had provided assurances that things would be

taken on board and action taken to address any concerns. During the next meeting it had been commented, "We love the way you have changed the aspects of the home and love the enthusiasm you and staff have for the residents and the home."

During the handover genuine concern was shown for people who were feeling a little poorly and in particular for those people who were in hospital. One staff member had returned from holiday and was told that some people had, sadly, passed away. Respect and compassion was shown for the person who had passed, and for their family and staff when this news was shared. Staff paid their respects to people and were genuinely saddened to hear of peoples' passing.

Staff described the best things at Appleby as being the people. One staff member said, "It's the residents, knowing they are fine, and happy, talking with them and being a part of it, talking about the past." They added, "If we were ever short staffed I would come in for the residents, they've become part of my family." The administrator said, "I love it here, I love the residents. Everyone has a history and it gives you at talking point so you can get to know people." A staff member said, "I love it, I love putting a smile on their faces."

Good

Is the service responsive?

Our findings

Records were completed to support the staff to provide personalised care however we found the quality of care records varied. The registered manager said, "We are working on care plans to make them more understandable." Some were very thorough whilst others lacked detail. For example, one person's mobility care plan included information on their mobility, how to support them if they experienced a seizure and their risk of choking. A specific care plan was in place for the management of their epilepsy but it did not contain as much detail as the mobility care plan. Likewise, another person's mobility care plan included the use of as required medicines to support people who were anxious and distress. This medicine could make them unsteady so increased the risk of falls which was detailed on the mobility care plan, however, their care plan in relation to supporting them with distressed behaviour only mentioned that they were prescribed medicines as a last resort. Other information in this care plan was detailed and included potential triggers that distressed the person.

Care records contained all the information staff needed to support people safely and appropriately however it was not always documented in the most appropriately place. It had been identified on the development plan in June 2018 that care plans needed to be rewritten on the correct paperwork and in response to the inspection it was added that more detail should be added to care plans. A time frame for completion of this work had been included.

One staff member said, "The care planning and risk assessments are done by the nurses, and the daily notes. We do the food and fluid and daily records but we can add into the nurse's notes. "They added, "We read the care plans sometimes, they are really interesting about people's background but work is more based on observations and learning on the job. We could do with more time to read the care plans. Some rooms have key information about the person and the handover is detailed and helpful." We asked if they had enough information to support people safely. They said, "Oh yes we do."

This is your life documents were being completed by family members. The aim was that this would provide care and activity staff with information about people's likes and dislikes, their family history and any interests or hobbies. This information would then be used to develop meaningful activities for people. A staff member said, "It's good to have people's history and listen to their stories. [Person's] face lights up when you mention [relative]. We use their photo album which was taken by their husband and they recognise everyone. It's good for reminiscence. People have amazing stories."

Staff were supporting people at the end of lives. One staff member said, "I would like to do more palliative care training. Staff need to remember that people's death is important. We ask people how they want to be supported as it can make a real difference to people. We always make it happen so someone is always with the person they are never alone." They went on to say, "We support each other through bereavement and give a cuddle, you can't change people's nature and it's human to be upset."

A palliative care register was in place. People estimated to be within the last six to twelve months of life are

generally placed on the palliative care register. This supports nursing staff in arranging coordinated, appropriate care for people nearing the end of their lives.

Two activities coordinators were in post so weekend activities were available for people. We were also told that a minibus was available so people could enjoy daytrips. Dominoes and card games were taking place and people had access to other games if they choose to. During the inspection some people were outside working in the garden with the maintenance person and an activities co-ordinator. Some people were also sitting outside enjoying an ice-cream. For people who chose not to sit outside they were asked if they would like an ice-cream and this brought in for them. Music was playing and people were singing along or having a dance. There were mixed views about activities. One person said, "I think there is enough to do yes, I like playing cards." Other people said, "I just like my own company, I don't really join in with much." Another person said, I sometimes join in, it depends what's happening."

An area on the first floor had been refurbished into a bar area which was used in the evenings. We were told it was very popular during the World Cup for watching the football and it was also used for parties and functions. On the ground floor an activities room was being developed which included some sensory lighting. New furniture had been ordered and a relative said, "We are looking forward to getting some soft seating in here."

Concerns and complaints were logged, including concerns raised during relative's meetings. The registered manager said, "I wanted people to see we were listening and action in their concerns so everything is logged and responded to and we put feedback on the 'you said we did' board." Acknowledgement letters and outcome letters were also sent to complainants. People and relatives said they had no complaints, but if they did they explained they would have no problem raising it and felt comfortable to speak with the staff or the registered manager. One relative said, "I don't have complaints here. I am happy with everything. My [family member] is happy here and likes the staff."

Compliments were also logged and included, "Care from every member of staff has been fantastic."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and supported the inspection. Their registration had been completed on 7 August 2018 but they had been in post since February 2018. Appleby is registered to provide accommodation with nursing care for up to 55 people. At the time of the inspection the registered manager explained that some conversion work had taken place and the capacity had reduced to 50 people. This had improved the communal spaces available for people however no application had been made to change the condition of registration. The registered manager said they would raise this with the provider.

The governance and quality assurance system had not identified some of the areas for improvement found during the inspection. Some capacity assessments and best interest decisions were over a year old and had not been reviewed. Some people who lacked capacity did not have evidence of documented decision making in relation to the use of restrictions to keep them safe. Some care documentation contained limited detail, particularly in relation to people who became distressed and anxious. Not all risks had been assessed and mitigated and some risk assessments had been in place over a year with no evidence of a robust review.

There were some concerns with regards to the documentation of medicines which the registered manager said they were aware of and were going to address at the next changeover of medicines. The regional manager had identified on an impact report in June 2018 that improvements were needed to the management of medicines. In the July 2018 audit it had been identified that improvements had been made and signed off by the registered manager but improvements were still needed with the storage and recording of creams. We found these concerns remained and had not been added to the development plan until 13 August 2018 which was after the inspection had raised concerns with regards to the documentation of medicine management.

Daily and monthly audits of medicines had been completed but these they hadn't identified the areas of improvement we noted. There was no system to track which people's medicines were being audited each month so one person's medicines had been audited each month for three months, whilst other people's medicines hadn't been audited at all.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

The provider had an internal quality team. The registered manager said, "We are rated green with our quality visits, the come in every six months unless there's an issue. We have dealt with any areas of improvement. Specialist training has been provided by the behaviour that challenge team." They added, "Staffing changes have been made and the team are taking things on board and learning."

There was an organisation framework for governance and quality assurance and the registered manager had introduced some additional measures for assessing compliance and leading on improvements. They had introduced a 'room inspection' which was an assessment of the condition of bedrooms. Whilst staff had noted if improvements were needed such as a new lightbulb or a tap needing fixing there was nothing

documented on the inspection record to indicate whether these repairs had been made. The registered manager, "It's logged in [handyman's] book."

We saw some improvements were still being made, for example in relation to social profiles for the people supported and updating medicine profiles so they included a colour coded system to identify if people had an authorised DoLS or a DNACPR. The registered manager said, "We are getting up to date photos for the profiles and completing them electronically. They will be printed off though but it's easier for updating and it's legible."

The administrator said, "[Registered manager] is very organised, they sort problems out and say what it is that's needed. They are a nice person and are building a good team, there's a good bunch of nurses and everyone is on the same page. Respectful relationships between people so it's more balanced. The new staff have had a positive influence."

The registered manager spoke about the providers reputation in relation to another one of their locations which was now no longer operating. The registered manager said, "We've worked hard to get rid of the poor reputation and know that stability is important for everyone." This related to the providers reputation which had been affected following the inspection of another of their locations in December 2016. They said, "Our vision is that the home will be more dementia friendly, a home with a hotel feel." It was felt by the management team that the nurses were promoting person centred care. The registered manager said, "The nurses review daily logs and care plans, we've renewed care plans and looking at more training for the future with priorities being mental health and challenging behaviour."

The regional manager said, "The staff want to work hard, they are only bothered about Appleby and its reputation. They are happy as [registered manager] is doing what he said he would." The maintenance person said, "Moral is much better, we can have a laugh and carry on and involve people. We have fun days, army days, Grease days." They added, "We want improvements, [regional manager] recognised there was a problem and [registered manager] appeared and acted on things straight away."

One staff member said, "[Registered manager] has made improvements it's more of a home for people now." Relatives were happy with the way Appleby was being managed. One relative said, "I am happy with the staff here and the manager. I feel [family member] is in a good place and they do a good job." Another relative said, "If I ever needed to speak to the manager about anything I would feel comfortable doing so."

The regional manager said, "We need a sustainable manager, we met with the families on a weekly basis after the previous manager left to offer assurances. Family members were offered the opportunity to be involved in the recruitment of the manager and one family member agreed to act as the representative and be involved."

The registered manager explained there were various methods of engagement such as staff meetings, supervision and appraisals and relative meetings. They said they had held two meetings with relatives. During the initial meeting relatives had raised concerns about stability and consistency but during the second meeting no complaints had been raised. Any concerns raised during meetings were added to the complaints log so action taken could be tracked.

Staff told us there were team meetings they could attend and a communication book was used were they could find minutes of meetings. One staff member said, "We can raise any concerns, the manager and the seniors are approachable." Minutes were available and included staff being thanked for the work they were doing. Areas for discussion included training, appraisals, reminders to ensure people were encouraged to

drink in the hot weather and aspirations for making Appleby 'the best home.'

The registered manager explained they were looking to develop community engagement more. They spoke about the provider sponsoring a local football team and establishing links with the local RNLI who would become the provider's charity of the year.

The regional manager explained how continuous learning was being used to improve the service. They said, "The environment is more dementia friendly, increased training and activities and we're using the butterfly approach." They described this as being regular, short periods of engagement, interaction and activity. They added, "Safeguarding alerts are much lower now, it's why we developed the themed areas and are providing short activities. Positive behaviour training has been provided by the NHS behaviour team."

The registered manager described the biggest challenge as, "Getting rid of stigma and making environmental improvements." They said they were most proud of, "The home, the changes and the staff."

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person. Mental capacity assessments and best interest decisions were not always recorded for the use of restrictive equipment. Where mental capacity assessments and best interest decisions had been recorded they were not always reviewed to ensure the decision remained relevant and appropriate. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been fully established and operated effectively to ensure compliance. There was a failure to effectively asses, monitor, mitigate, and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user were not fully maintained. Regulation 17(1); 17(2)(a)(b); 17(2)(c)