

Vishomil Limited

St Winifred's Nursing Home

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Inadequate



Overall summary

We inspected St Winifred's Nursing Home on 11 and 12 August 2015 and the first day of inspection was unannounced. Our previous inspection took place in June 2013 and at that time we found the service was not meeting one regulation we looked at relating to medicines. We returned to the service in September 2013 and found improvements had been made and the service was compliant with this regulation.

St Winifred's Nursing Home provides accommodation for people who require nursing or personal care situated in

Rastrick a suburb between Huddersfield and Halifax. There is a car park to the front of the building and a courtyard in the middle of the building where people can sit in the nice weather. There are single and double bedrooms available many of which have en suite facilities. Of the thirty three people using the service on the day of inspection seventeen required residential care and sixteen required nursing care.

The home had a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

The home had a safeguarding policy in place which made staff aware of their roles and responsibilities. We found staff knew and understood how to protect people from abuse and harm and kept them as safe as possible. However, we found staff were not following the procedures in place for safeguarding people's money held in safekeeping, which might lead to mistakes being made.

We were concerned that there was not always sufficient staff on duty to meet people's needs and that staff did not always receive the training and support they required to carry out their roles effectively.

There were procedures in place and guidance was clear in relation to Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) that included steps that staff should take to comply with legal requirements. However, the staff we spoke with did not have a clear understanding of the MCA or DoLS or when Best Interest Decisions needed to be made to safeguard people. This legislation is used to protect people who might not be able to make informed decisions on their own.

We saw arrangements were in place that made sure people's health needs were met. For example, people had access to the full range of NHS services. This included GPs, hospital consultants, community health nurses, opticians, chiropodists and dentists. However, we found the guidance and advice provided by other healthcare professionals was not always followed and people were not consistently receiving appropriate support to meet their nutritional and hydration needs.

We also found that although medication policies and procedures were in place medicines were not always administered as prescribed.

People told us they found the staff caring, and said they liked living at the home. Relatives gave us positive feedback about the care and support their family members received. Throughout the inspection we saw staff were kind, caring and patient in their approach and had a good rapport with people.

Staff were careful to protect people's privacy and dignity and people told us they were treated with dignity and respect. We saw information relating to people's care and treatment was treated confidentially and personal records were stored securely.

We saw the complaints policy had been available to everyone who used the service. The policy detailed the arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

Staff told us communication within the home was good and staff meetings and daily handovers were held to keep them up to date with any changes in policies and procedures or anything that might affect people's care and treatment. Staff were confident senior management would deal with any concerns relating to poor practice or safeguarding issues appropriately.

However, we found the quality assurance monitoring systems in place were not robust and therefore we could not be sure the service was managed effectively and in people's best interest.

We found five breaches 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 overall rating for this service is 'Inadequate' and the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement

Summary of findings

action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?

The service was not safe.

Medication policies and procedures were in place. However, medication was not always administered as prescribed which put people's health and wellbeing at risk.

The staff recruitment and selection procedure was robust and newly appointed staff were not allowed to work until all relevant checks had been completed and references received. However, staffing levels were not always adequate to meet people's needs which impacted on the care and treatment they received.

The staff we spoke with knew how to recognise and respond to allegation of possible abuse correctly and were aware of the organisation's whistleblowing policy.

Inadequate



Is the service effective?

The service was not effective.

The staff training matrix was not up to date therefore unable to establish if the staff team had received the training and support required to meet people's needs.

Although people were complimentary about the meals provided people did not consistently receive appropriate support to meet their nutritional and hydration needs.

We found the location was not meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

Inadequate



Is the service caring?

The service was caring.

People told us they found the staff caring, friendly and helpful and they liked living at the home.

We observed throughout the day of inspection people were treated with dignity and respect.

People's information was treated confidentially and personal records and reports were stored securely.

Good



Is the service responsive?

The service was not consistently responsive.

Requires improvement



Summary of findings

We saw people had access to the full range of NHS services and staff worked closely with community based healthcare professionals in specific areas of people's care.

However, we found care plans had not always been updated to reflect the advice given by other healthcare professionals and their advice had not always been followed. This meant the people were at risk of not receiving care and treatment that was appropriate and met their needs.

Is the service well-led?

The service was not well-led.

There were quality assurance monitoring systems in place which were designed to identify any shortfalls in the service and non-compliance with current regulations.

However, the system were not robust or consistently applied therefore we could not be sure the service was managed effectively and in people's best interest.

Inadequate



St Winifred's 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 12 August 2015 and the first day of the inspection was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the

provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We looked at seven people's care records, medicines administration records (MAR) and other records which related to the management of the service such as training records, staff recruitment records and policies and procedures.

We spoke with eight people who were living in the home, five relatives, five care staff, the cook, one qualified nurse and the registered manager. We also spoke with one visiting healthcare professional and the local authority commissioning service.

Is the service safe?

Our findings

We looked at how people's medicines were managed. There were policies and procedures in place. The home used two medicine trolleys and all the medicines were administered by the nurse in charge. On the second day of the inspection we observed the morning medicine round was not completed until 10.30am. The nurse in charge confirmed they had started to give people their medicines at 8am and said it was not unusual for the morning medicines to take two to two and a half hours to complete. We observed the nurse took time with people to explain, encourage and make sure people had taken their medicines.

The medicines fridge, which was in use at the time of the inspection, was in the reception office. The fridge was not locked. The registered manager said they would address this. The fridge temperatures were checked and we saw action had been taken when the temperature had not been within the recommended safe range. Medicines which were not kept in the trolley were kept in metal cabinets in a locked room. There was a storage cabinet for medicines classified as controlled drugs.

Some people's medicines were hand written on the Medication Administration Records (MARs). When this is necessary it is good practice for two people to check the medicines and sign the charts to reduce the risk of transcribing errors. This had been done on some charts but we found four MARs where hand written entries had not been signed at all.

In the records of two people who were prescribed a medicine which is used to slow down and strengthen the heartbeat we saw their pulse rate was not always recorded on the MARs. This meant it was not possible to confirm their pulse had been checked before the medication was administered.

We asked the nurse in charge about the arrangements for giving medicines where there were specific instructions about how it should be taken in relation to food. A number of people were prescribed a medicine which should be taken 30 to 60 minutes before food. The nurse in charge told us one person always had this medicine before their breakfast because it was given at 8am at the same time as

another medicine. However, they said other people who were prescribed the same medicines did not always have them before their breakfast because the medicine round took so long.

Topical treatments such as creams and lotions were recorded on the MAR charts. The nurse in charge told us they were administered by the care staff and signed for by the nurses. We asked the nurse how they could be sure the topical medicines they were signing for had been given. They said the care staff knew the creams and/or lotions had to be applied.

When people were prescribed medicines to be taken on an as required basis (PRN) there were no care plans to provide guidance on their use. The nurse in charge said the medicines prescribed in this way were generally for pain relief and most of the people for whom they were prescribed were able to say when they wanted them. They added they always asked people if they wanted pain relief when it was prescribed in this way.

One person who lived at the home was having their medicines in a disguised format. The person was assessed as not having the capacity to make an informed decision and we saw the best interest decision process had been followed and was clearly documented.

The registered manager told us they checked the medication records every week but did not make a record of this. They confirmed they did not carry out a full audit of the medication management systems. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

We saw there was a recruitment and selection policy in place. The registered manager told us as part of the recruitment process they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people. We saw there was a staff disciplinary procedure in place to ensure where poor practice was identified it was dealt with appropriately. The registered manager told us if they found a member of staff was no longer suitable to work in a health or social care setting they would make a referral to the appropriate agency, for example, the Disclosure and Barring Service. We looked at three employment files and found all the appropriate

Is the service safe?

checks had been made prior to employment. The staff we spoke with told us the recruitment process was thorough and done fairly. They said they were not allowed to work until all relevant checks on their suitability to work with vulnerable adults had been made.

The registered manager told us sufficient staff were employed for operational purposes. They told us staffing levels were based on people's needs and we saw a dependency tool was used to determine staffing levels. However, we saw that the dependency tool did not take into account the layout of the building. St Winifred's is a large extended building with accommodation split over two sides of the building therefore the layout of the building also needed to be taken in to consideration when determining staffing levels.

Records showed that night duty was covered by one qualified nurse and two care assistants. However, the registered manager told us that about 50% of people who used the service required two staff to assist them with their personal care needs during the night. This meant that during peak periods of activity only one member of staff was available to answer the nurse call alarms and provide assistance to other people on both sides of the building.

Records also showed that at the last two "resident and relative meetings" two people who used the service had said that they felt the home was short staffed and were told by the member of staff chairing the meeting that staffing levels were within the Care Quality Commissions (CQC) guidelines. CQC do not publish guidance on staffing levels. This was discussed with the registered manager who told us they had made a mistake and would ensure at the next meeting people were made aware of this. They also confirmed that in the future if people raised concerns about staffing levels they would be referred to the organisation's complaints procedure.

The relatives of two people we spoke with told us they had no idea the staffing levels on night duty were so low and expressed concerns about people's safety. One person told us "I actually thought there would be that number of staff on each side of the building; not for the entire building it is just not enough." **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager told us the service did at times use agency nurses to cover for annual leave and sickness. They confirmed that when agency staff were used they always requested the same nursing staff to ensure people received continuity of care.

We saw the service had policies and procedures in place to safeguard vulnerable adults. All the staff we spoke with demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy. However, the training matrix showed a number of staff had not updated their safeguarding training since 2010 even though the manager confirmed the organisation's policy was that it is updated on a three yearly basis.

We saw the provider had a policy in place for handling people's money and valuables which showed a monthly audit of the transaction sheets and money held would be undertaken by two staff one of them a senior member of staff. However, when we checked the actual money held against the transaction sheets we found two discrepancies whereby the actual money held did not cross reference with the transaction sheet. We also found that the system was not being audited in line with the policies and procedures in place. This was discussed with the registered manager who gave no satisfactory explanation as to why the audits had not taken place. **This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We completed a tour of the premises and inspected a number of bedrooms as well as bathrooms and communal living areas. We saw that some areas of the home required refurbishing and worn and tired furniture and carpets needed replacing. We saw the registered manager had identified a number of rooms that required refurbishment although they told us there was no planned programme of refurbishment in place.

We saw risk assessments were in place in relation to the environment. However, we found the doors to some high risk areas of the home including the sluice room and the cleaning store were not locked to ensure people's safety.

Is the service safe?

We also found two clinical waste bins were not pedal operated as required. This was discussed with the registered manager who took immediate action to address the concerns raised.

We saw fire-fighting equipment was available, emergency lighting was in place and all fire escapes were kept clear of obstructions. We also reviewed fire safety records and maintenance certificates for the premises and found them to be compliant and up to date.

Is the service effective?

Our findings

We observed the meal service in the dining room at lunch time. People were offered a choice of food and said they always enjoyed their meals. We observed one person had a pureed diet, all the components of the meal were pureed separately and the person said it all tasted good. People were offered drinks with their meals and the service was not rushed, people were given time to enjoy their food. There was music playing while lunch was being served, one person said they thought it was a bit too loud. The registered manager turned down the volume when they came into the dining room.

We spoke with the cook and they were able to tell us about people's dietary needs and preferences. They told us they had a six weekly menu and the menus changed in summer and winter. They said the menus were discussed at the "residents" meetings and they also saw people individually to talk about their dietary needs and preferences. The cook told us they were able to cater for special diets, for example when people needed a diabetic or gluten free diet. At the time of the inspection none of the people living in the home were following a special diet linked to their cultural or religious background. The cook told us they provided extra butter, cream and cheese for people who needed their food fortified. They said the nursing and care staff were responsible for ensuring this was added to people's food when they were identified as being at risk.

In the records of one person who used the service we saw their weight had increased by 0.8kg between May and August 2015. Their care plan about eating and drinking stated they should have 200mls of fluid eight times a day. However, the person did not have a fluid chart and there was nothing else in place to show whether this was being achieved or not.

In the records of another person a nutrition risk assessment had been carried which identified them as having a medium risk of malnutrition. However, when we looked at the person's weight records we found they had lost at least 4.6kgs between May 2015 and August 2015. There was a discrepancy in the weight records for May 2015 which meant we could not be sure exactly how much weight they had lost. In one part of their records the weight was recorded in May 2015 as 44.3kgs and in another it was recorded as 43kgs. The person's weight was recorded as 38.4kgs in August 2015. At the time of the inspection this

had been referred to the local safeguarding team by a visiting health care professional who had concerns that the person was not getting the right support to meet their nutritional needs.

In another person's care records we saw they had lost 5kgs in weight in nine months. In November 2014 their weight was recorded as 48.5kgs and in August 2015 it was 43.5kgs. A nutritional risk assessment had been carried out on 10 August 2015 which showed the person had a medium risk of malnutrition despite the gradual but continued weight loss. The records showed the person had been seen by a Speech and Language Therapist in June 2015. The person was prescribed a thickening agent and a food supplement, Complan. The person's eating and drinking care plan showed they should have two scoops of the thickening agent in 200mls of fluid and should have Complan once a day. The care plan stated the person's dietary intake should be observed and recorded. The care plan did not state how much fluid or food the person should have in a day nor did it give any indication of the target weight. The person's dietary intake was recorded on a weekly chart and we looked at the charts for a period of 14 days starting on 27 July 2015. The charts were not filled in properly and did not provide enough information to effectively monitor the person's dietary intake, for example daily fluid intake was not added up at the end of the day. On most of the charts the three main meals of the day were recorded but there was no record of any snacks between meals or anything eaten after the evening meal. The use of the prescribed thickening agent in the person's drinks was not consistently recorded. In addition, it was not clear if the person was receiving their supplement every day. When we added up the charts we found over a period of 14 days the highest daily fluid intake recorded was 1150mls. On eight of the 14 days the charts showed the person had 500mls or less of fluid and on one occasion there was only 200mls recorded. This is not an adequate fluid intake.

We looked at the food and fluid charts for three other people and found similar issues. We asked the nurse in charge what the process was for monitoring the food and fluid charts to ensure people who were identified as being at risk were receiving an adequate dietary intake. They told us there was no process in place for checking the charts. They said the completed charts were taken to the office for

Is the service effective?

filing, they didn't know if they were checked at this point. The nurse confirmed the food and fluid charts were not checked and reported on as part of the handover between shifts.

On the second day of the inspection we found staff had added up the fluid charts for the previous day.

We found people were not consistently receiving appropriate support to meet their nutritional and hydration needs. **This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People, when appropriate, should be assessed in line with DoLS as set out in the Mental Capacity Act 2005 (MCA). We were told by the registered manager no people who used the service were subject to authorised deprivation of liberty.

However, after lunch we observed a person in the lounge/dining who room was asking to go home. They said "I want to go home now, I've had enough." They continued to ask to go home for approximately 10 minutes and became increasingly upset as staff spoke to them but carried on attending to other people. After about 10 minutes one of the staff said they would come back as soon as they had finished what they were doing. The person sat quietly for a few minutes but the care worker did not come back and the person started to get upset again, they were shouting and banging the arms of the chair. A care worker came and spoke quietly to the person and they agreed to go with them to their room. We looked at the care records and they showed the person was living with dementia and lacked capacity. We asked the registered manager if they had made an application for a Deprivation of Liberty Safeguarding authorisation for the person and they said they had not. This created a risk the person was being deprived of their liberty without lawful authority. **This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

We looked at one person's records and saw the best interest decision making process had been followed and clearly documented in respect of a decision to administer medicines covertly. However, we found the provider was not consistently applying the best interest decision making process and was not always acting in accordance with the

requirements of the Mental Capacity Act 2005 (MCA). For example; in another person's records we saw a mental capacity assessment had been carried out in July 2014. The assessment stated the person was living with dementia and had the capacity to make simple decisions but not more complex choices. The records stated the person had agreed a relative could sign consent forms on their behalf. In the same person's records a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) form had been completed in September 2014. The DNACPR form stated the decision had been discussed with the person and they had the capacity to make the decision that they did not want to be resuscitated in the event of their heart stopping.

We looked at a third person's records and found an assessment of capacity had been carried out in May 2015 which stated they could make small decisions but on balance lacked capacity. The outcome of the assessment was to "proceed to best interests". We saw the person used a lap belt when they were in a wheelchair, the records showed this was because the person was at risk of falling. However, there was no evidence to show the best interest decision making process had been followed, there was no record of when the decision was made, who was involved in the decision making or if any attempt had been made to find out how the person felt about it.

In the records of a person who was living with dementia we saw a care plan about their mental state. The care plan stated the person had fluctuating capacity and was not able to make complex decisions. The care plan stated their relative was involved in decision making. A mental capacity assessment had not been completed. The person had bed rails and bumpers on their bed and had an alarm on their chair which alerted staff when they moved. There was no evidence the best interest decision making process had been followed in respect of these interventions.

The staff we spoke with did not have a clear understanding of the MCA or the Deprivation of Liberty Safeguards (DoLS) and how they applied to their day to day work.

The registered manager told us all new staff completed induction training on employment (care certificate) and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. We saw evidence all new staff had signed to confirm that they had received copies of the organisation's key policies and procedures.

Is the service effective?

The registered manager told us training issues were normally discussed with individual staff during their formal one-to-one supervision meetings. However, we saw staff had been given the opportunity not to have a formal meeting but for the registered manager to observe their care practice and then discuss their performance with them. Formal supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern.

The registered manager told us the majority of staff training was facilitated by external training providers including the local authority training unit. We saw that the registered manager had identified the staff team's training needs for 2015 but there was no indication when the training would

be done. We looked at the training matrix and found a number of gaps whereby staff had not updated their training as required. For example; we saw in the reception area there was a list of trained first aiders on display. However, when we checked the names on the list against the training matrix we found only one of the six named staff held a current first aid certificate. This was discussed with the registered manager who told us the matrix was not up to date but acknowledged some staff had not updated their training as required. The provider was therefore unable to demonstrate the staff team had received the training and support required to meet people's needs. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Is the service caring?

Our findings

People who lived at the home and people's relatives told us the staff were caring and friendly. They said staff treated them with kindness and respect. One person who had only recently been admitted said, "Although I have only been here a short period of time I have found the staff to be very caring and approachable." The relative of another person told us, "We visited several care homes before deciding on St Winifred's and I am sure we made the right choice. I visit several times a week and I am always made to feel welcome and have never had any concerns about the quality of care provided."

Throughout the inspection we observed staff were kind, compassionate and respectful in their interactions with people. They were able to tell us about people's individual preferences and we observed people looked comfortable and at ease in their presence.

On the first day of the inspection we spent some time in one of the lounge areas. We saw people had cold drinks within reach. Just after 10am people were offered hot drinks, a choice of tea or coffee and one person was asked if they wanted "milky coffee". We observed staff supported people appropriately and discreetly. They addressed people by name and were attentive to people's needs, for example, they closed the blinds because the sun was shining on the TV screen and one person could not see the screen properly. They were encouraging when helping people, while supporting someone to walk with a Zimmer frame we heard them say, "You are improving every day."

We observed staff helping one person to move with the aid of a hoist. They explained what they were doing, spoke with the person throughout and asked them if they would prefer to sit in the dining room and read. We saw the person in the dining room reading, they told us they didn't like noise and enjoyed the quietness of the dining room.

During the morning we observed one of the care workers had a flower in their hair and they were asking people who

lived in the home if they also wanted a flower in their hair. Some people did and others declined. When speaking with one person we heard them say, "Squeeze my hand if the answer is yes." This showed they understood how the person communicated. The flowers provided an opportunity for individual engagement and also provided a topic for conversation. The care worker told us the idea had come from training they were undertaking about supporting people living with dementia. They said it helped reduce the barriers between care workers and people living in the home.

We observed staff were respectful of people's dignity and saw this was considered when planning care. For example, in one person's care plan we saw there was an entry which stated they usually wore trousers to preserve their dignity because they sometimes sat with the legs over the side of the chair. We saw the person was wearing trousers on both days of the inspection.

At lunch time we saw people had aids such as adapted cutlery and plate guards to help them maintain their independence.

Staff spoken with told us that they respected people's privacy by ensuring they knocked on bedroom doors and spoke to people when entering. One staff member told us, "When I am helping a person with personal care, I always make sure the bathroom or bedroom door is closed." We saw evidence of this during the course of the inspection.

The registered manager told us no one who lived in the home had an advocate at the time of the inspection. However, they confirmed they would assist people to access an independent advocacy service if required.

All of the relatives spoken with told us that they could visit the home whenever they wished to. One person told us, "I visit at different times and it is okay for me to do that." Staff told us that there were no restrictions on relatives or friends visiting people.

Is the service responsive?

Our findings

The relatives of one person who lived at the home told us they were fully involved with all aspects of the person's care. They said they were kept well informed about any changes to the person's needs and/or their care and treatment. However, another person's relative told us they had not been involved in planning or reviewing the care and they had not been informed about significant changes in the person's care needs.

People's needs were assessed and there were care plans in place but they did not always provide an accurate picture of people's needs and care/support staff should provide. For example; in the records of one person who was living with dementia and who was identified as being at risk of falling we saw several entries where staff had recorded the person was constantly standing up and walking around. The records showed staff responded to this by asking the person to sit down. There was no care plan to guide staff on how to support the person with this aspect of their care.

Over the two days of the inspection we observed the person sitting in an area where there was a lot of activity and it was evident they enjoyed engaging with people as they walked by. The person was also engaged looking at newspapers and magazines. This showed us staff had considered how to support the person but this was not recorded which created a risk the person would not consistently receive appropriate support.

In the same person's records we saw they had been identified as having a high risk of pressure sores. There was no information in the care plan to show what was being done to reduce the risk. We saw the person had an air mattress on their bed; it was set at "medium." This type of mattress is used to help reduce the risk of pressure sores but to work effectively it has to be set correctly, this is usually determined by the person's weight. There was no information in the care plan to guide staff on the correct setting for the mattress. We asked the nurse in charge and they said they didn't know, they thought the mattress had been on the bed when the person moved in. This showed the planning and delivery of care was not responsive to individual needs.

After lunch we observed a person who lived at the home became anxious and upset and was repeatedly asking to go home. We saw the staff were busy helping supporting

other people and every couple of minutes one of the staff would tell the person they would attend to them shortly or suggest the person had a drink of juice. After about 20 minutes the person was very upset and was shouting and banging the arms of the chair. One of the care workers went and spoke quietly to the person and they agreed the person would go to their room. A little while later the person came back to the lounge with the same care worker and they were content to sit and watch the TV. We asked the care worker about the person's needs and they said when they talked about going home they wanted to go to their room. They said the person had been upset because they needed some help with personal care. We looked in the person's care records and this was not recorded. This created a risk their needs would not be met as other staff would not know how to interpret their behaviour.

In one person's records we saw a specialist nurse had been involved in planning their care. However, we found the person's care plan had not been updated to reflect the advice given by the specialist nurse. We also observed the person's support was not being delivered in the way the specialist nurse had advised. In the same person's records we saw the night care plan stated they should be checked at half hourly intervals because they were at risk. When we looked at the daily care notes they showed the night staff were carrying out checks at two hourly intervals. This meant the person was at risk of not receiving care and treatment that was appropriate and met their needs.

The registered manager told us the service employed a part time activities co-ordinator and people were encouraged to join in a range of social and leisure activities. The registered manager told us there was no one living at the home that had any particular cultural or religious requirements. However, we saw church services were held at the home and information about the times of services and all planned activities were displayed on a notice board in the reception area.

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The policy also detailed the timescales within which the complainant would be dealt with.

The relatives we spoke with told us that they knew how to make a complaint and would have no hesitation in making

Is the service responsive?

a formal complaint if the need arose. One person said, “I’ve no complaints, everyone is extremely friendly and caring.”

Another said, “I visit at different times of the day and have never seen anything which causes me concern. The staff work very hard and at times seem overstretched but they are always friendly and professional.”

Is the service well-led?

Our findings

We saw the registered manager completed a range of audits on the quality of the service provided. However, we found the shortfalls in the service identified in the body of this report that had not been identified through the quality assurance monitoring systems in place.

For example; we found the training matrix was not up to date, medication was not always administered as prescribed and people were not consistently receiving appropriate support to meet their nutritional and hydration needs. Had the quality assurance systems in place been robust all these areas of concern would have been identified sooner and without them being brought to the attention of the registered manager through the inspection process.

We saw the registered manager audited accidents and incidents and analysed the information and looked for themes and trends. We saw the outcome of the audits resulted in an action plan to ensure areas in need of improvement were acted upon.

The registered manager told us no internal infection control audit was carried out although they did walk around the building on a daily basis to ensure standards were being maintained. We saw a recent care plan audit had been carried out although this was a series of hand written notes.

We saw there was a kitchen audit tool in place which was completed every two months by the cook to ensure standards of cleanliness and hygiene were maintained.

The registered manager confirmed that they were aware not all the audits were up to date. They told us this was because the service had for a five month period been short of qualified nursing staff which meant they had worked as a nurse and provided “hands on” care.

We saw a director of the company visited the service on a weekly basis and completed a monthly report on the service. We looked at the reports completed for July and August 2015 and found in the record and document section of the report they had recorded “All residents monies held by the home audited and correct.” However, the records we looked at showed regular audits were not being carried out

and we found two discrepancies between the money held and the financial transaction sheets. This raised concerns about the effectiveness of the quality assurance monitoring process. **This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager told us as part of the quality assurance monitoring process the service sent out annual survey questionnaires to people who used the service, their relatives and other stakeholders on an annual basis. They confirmed the information provided was collated and an action plan formulated to address any concerns raised.

We looked at the results of the last survey completed on the August 2014 and found the majority of comments made were positive about the care and facilities provided. We saw some negative comments had been made about the environment including the need to update the toilet and bathroom facilities and the registered manager had put this work on the list of identified improvements required. The registered manager told us that staff and stakeholder questionnaires were also usually sent out on an annual basis but confirmed the last surveys had been done in 2013.

The relatives we spoke with told us they had confidence in the registered manager and staff team and were generally pleased with the standard of care and support they received. One person said; “I am very pleased with the standard of care provide.” Another person told us, “I cannot fault the care provided and I have always found the manager to be approachable and willing to listen.”

The staff we spoke with told us that the registered manager operated an open door policy and were confident that any issues they raised would be dealt with promptly. We asked staff if the registered manager was open to change and they told us they felt they could make positive suggestions and people could speak up if they had concerns or ideas.

We saw staff meetings were held about every six months to ensure all staff were kept up to date with any changes in policies and procedures, which might affect the management of the service. In addition, we saw daily handover sessions took place every day which ensured staff were kept up to date with people’s changing needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered person did not have suitable arrangements in place to ensure people who used the service received their medicines as prescribed.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support and training to enable them to carry out the duties they were employed to perform.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The registered person did not have suitable arrangements in place to ensure people's nutritional and hydration needs were appropriately met.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The registered person did not have suitable arrangements in place to ensure people who used the service were not deprived of their liberty.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not have suitable arrangements in place to regularly assess and monitor the quality of the services provided and to identify, assess and manage risks.

The enforcement action we took:

Warning Notice

To be met by 30/11/2015