Stocks Hall Care Homes Limited

Andrew Smith House - Nelson

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 July 2018, the first day was unannounced.

Andrew Smith House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Andrew Smith House is registered to provide nursing and personal care for people living with dementia, old people physical disability, nursing care and mental health care needs. It is situated in Nelson, Lancashire. Accommodation is provided on four units on two levels, with a lift to both floors and wheelchair access to all parts of the home. The home can accommodate up to 60 people. At the time of this inspection, there were 44 people who lived in the home.

The service had a registered manager in place. 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.

We previously inspected this service in June 2016. The registered provider was compliant with all regulations at that time and the service was rated overall 'good'.

During this inspection we found shortfalls in relation to the management of risks associated to receiving care. This was because risks to people and incidents had not always been analysed to identify patterns and ensure lessons were learnt. People's medicines had not been safely managed and staff recruitment procedures were not robust to protect people. There were significant shortfalls in staff training. Quality assurance systems were not effective in identifying shortfalls or areas where the service was not meeting regulations and failure to drive improvements. In addition, there was a failure to demonstrate how the provider had promoted a culture that encouraged candour, openness and honesty.

We found there were six breaches of the Regulations. These were breaches of Regulations 12,17,18,19 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

Staff had received safeguarding training and knew how to spot abuse and the reporting procedures. Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. However, there had been significant incidents that exposed people to risks. Some significant incidents had been reported to the local authority and the Care Quality Commission however, there was no robust formal system to analyse incidents. Accidents and incidents had been recorded and staff had sought medical advice where required however, there was no evidence of lessons learnt. Improvements were required to demonstrate what support people had received following incidents such as repeated entrapment by

bedrails.

Staff had been trained in the safe management of medicines. However, there were some shortfalls in medicine management practices in the home.
Safe recruitment procedures had not always been followed to ensure new staff were suitable to care for vulnerable people. Arrangements were in place for training staff however we found significant shortfalls in training. Staffing levels were monitored to ensure sufficient staff were available.
Policies and practices for promoting, honesty, transparency and duty of candour had not been effectively followed when things had gone wrong with people's care.

There were established governance arrangements and quality assurance processes. The provider had considered best practice and had been involved in the trial of innovative practices in collaboration with other agencies. However, the shortfalls we identified in people's care showed the quality assurance processes were not robust and needed to be improved to ensure they identified where the service was not compliant with regulations.

Feedback from people and their relatives regarding the care quality was positive. People who lived at the home told us that they felt safe. Visitors, people who lived at the home and care staff spoke highly of the registered manager.

People were happy with the care and support they received and made positive comments about the staff. They told us they felt safe and happy in the home and staff were caring. People were comfortable in the company of staff and it was clear they had developed positive trusting relationships with them. However, our records showed that there were incidents in the home which had compromised people's safety.

The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. However, some improvements were required to ensure records of people's consent were kept.

The information in people's care plans was detailed to ensure they were at the centre of their care. Majority of people's care and support were kept under review however this was not consistent throughout the records we checked. Relevant health and social care professionals provided advice and support when people's needs changed. People's nutritional needs were met. Risks of malnutrition and dehydration had been assessed and monitored.

The home was clean, and comfortable for people to live in. The environment was dementia friendly and the home had adaptations designed to suit the needs of people living at Andrew Smith House.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff respected people's diversity and promoted people's right to be free from discrimination.

There was a strong drive to facilitate community and social inclusion. People had access to a range of appropriate activities both inside the home and in the local community.

People were supported to maintain and develop their independence. The provider had sought people's opinions on the quality of care provided.

People who used the service knew how to raise a concern or to make a complaint. The complaints

procedure was available, and people said they were encouraged to raise concerns and were confident they would be listened to.

The registered manager and staff co-operated with the inspection and were keen to rectify all the shortfalls we identified. They took corrective measures to rectify a significant amount of the concerns during the inspection and soon after. However, we would have expected these issues to have been identified by the provider and rectified without our intervention.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not safely managed.

There were risk assessments in place however some risks were not adequately monitored. Accidents and incidents were recorded however there was no analysis to identify trends and learn from incidents.

Safe recruitment practices had not always been followed. There were sufficient staff available to meet people's needs. However, improvements were required in one unit of the home.

People felt safe in the home and were protected against the risk of abuse. Some staff had received safeguarding training.

Risks of infection had been managed and equipment serviced regularly.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff had been provided with training and professional development however there were significant shortfalls in various areas of training.

People's consent was sought however documentation on mental capacity was not always completed.

The environment was maintained to provide safety and comfort for people. A system of reporting required repairs and maintenance was in place.

People enjoyed their meals. Their dietary needs and preferences were met.

People were supported appropriately with their healthcare and were referred appropriately to community healthcare professionals for ongoing support and review.

Is the service caring?

Good

The service was caring.

Staff knew people well and good relationships had developed between people and the staff.

People were encouraged to maintain relationships with family and friends.

Staff respected people's rights to privacy, dignity and independence. Where possible, people were able to make their own choices and were involved in decisions about their day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's changing needs and risks were not consistently monitored to prevent re-occurrences.

Care plans had been reviewed after incidents however this was not consistent.

There was a significant drive to promote social inclusion. People were supported to take part in suitable activities inside and outside the home. Action was being taken to recruit an activities organiser.

Majority of the people had a care plan that was comprehensive and reflected the care they needed and wanted.

People told us they knew who to speak to if they had any concerns or complaints and were confident they would be listened to.

The provider supported people effectively with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems to assess monitor and improve the quality and safety of the service needed further improvements. Care plans had not been audited and systems for providing oversight on unit managers was not robust.

Systems and processes for ensuring lessons were learnt from incidents were not effective. Practices for promoting honesty and

transparency were not robust.

There were systems in place to seek feedback from people living in the home, visitors and staff.

People made positive comments about the registered manager and staff. They felt the service was well managed

Andrew Smith House - Nelson

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 19 and 20 July 2018 and the first day was unannounced. The inspection was carried out by three inspectors, a pharmacy inspector who specialised in medicines 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. They had experience of caring for an older adult.

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.

Before the inspection we reviewed the information we held about the service such as notifications and safeguarding information. Following the inspection, we asked for feedback about the service from community based mental health professionals. We received positive feedback about the service from three health and social care professionals.

Prior to this inspection CQC were aware of two significant incidents that had occurred at the home. These incidents had been brought to the attention of the Police and/or the Local Authority. The inspection considered action that had been taken to reduce the risks and the likelihood of re-occurrences.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the registered manager, the deputy manager, two nurses, two senior carers, eight care staff and the chef and the maintenance person. We spoke with nine people who

lived in the home and three visiting relatives. We also contacted the director of the service following the inspection.

We looked at a sample of records including nine people's care plans and other associated documentation, six staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, medicines records, internal inspection reports, maintenance certificates, policies and procedures and quality assurance audits.

Inadequate

Is the service safe?

Our findings

We looked at how risks to people's health and well-being were assessed and how people were monitored so they could stay safe and have their freedom respected. We found accidents and incidents had been recorded and support had been sought from emergency services and health professionals where this was required. Staff had also reported significant incidents to the local safeguarding authority in line with local and national guidance. Accident and incidents had been recorded in each person's individual record. However, there was no evidence to demonstrate how all accidents and incidents that had occurred had been analysed to identify patterns and trends within individuals or throughout the home. In addition, incident records had not been overseen by management to check whether staff had taken the correct action to support people. For example, we found incident records that showed one person had experienced five separate incidents of being trapped by a bed rail incurring injuries on some occasions. However, we found no risk assessments had been completed following all the incidents. There was no bedrail risk assessment to show how risks of such as entrapment had been considered before the rails were introduced. Monthly reviews had been undertaken and staff had recorded that 'there was no change' to the person's needs regardless of the incidents and the injuries. This meant that the person continued to be at risk of further incidents of entrapment and potential injuries. We immediately informed the registered manager and staff of these concerns and asked them to take action. They took immediate action to assess the risks and to put preventative measures in place.

Lessons from significant incidents and events in the home had not adequately been shared and used as learning points to reduce further incidents. Before our inspection a serious incident had occurred in the home resulting in serious injuries. The provider and the registered manager had informed us of the actions they had undertaken to reduce the risks and we observed them to be robust. However, in March 2018 we were notified of another incident where two people had left the premises without staff knowledge. Whilst the incident did not result in significant harm to the people involved, the circumstances of the incident were similar to the earlier incident. This meant that protective measures introduced has not been adequately imbedded to demonstrate that lessons had been learnt. Investigations were carried out by the local authority who substantiated allegations of neglect as a result of these incidents. We noted that the provider undertook their own investigations and established the cause of the latest incident as human error. They changed their security systems in the home to ensure all exits from the home were alarmed and the system could not be disarmed by anyone other than when the fire alarm is activated. Staff were also informed security codes were not to be shared between staff where they could be overheard or shared with visitors or relatives.

During our inspection the registered manager and the deputy manager took immediate action and introduced a system for overseeing all accident and incidents that occurred in the home and also a system to analyse and share lessons from significant events with staff. However, we would have expected this to have been identified and rectified without our intervention.

Risk assessments had been undertaken in keys areas of people's care such as falls, nutrition, choking, drug or alcohol misuse and risk of self-harming. In some cases, the registered manager had reviewed risk

assessments and took appropriate action when people's needs, or risks had increased. For example, we found they had reviewed one person's support needs when their behaviour and mental health presentation changed. There was a review and update in their care plan to demonstrate the change in risk and changes to the measures that were required to minimise the risks to this person's health and wellbeing. In addition, they had requested other health care professionals to undertake reviews where necessary. However, during the inspection, we noted risk management was not robust in one of the units. We noted that one person had been assessed as at risk of choking and had experienced a choking incident while in the home. We noted that the person was at continued risk of choking if food was left on display and the person was not supervised. We observed food had been left on display and the person was not supervised. This exposed the person to risks of choking as they were unpredictable and known to grab food and swallow quickly without chewing. We also found the staffing arrangements on the particular unit were not adequate to ensure that those who required constant supervision could be monitored adequately at all times. During the inspection we asked for action to be taken with regards to staffing and choking risk management. This was done immediately.

This meant that arrangements for managing risks in the home were not robust and did not ensure that lessons were learned from significant events.

These issues meant that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed in the home. Medicines were not managed safely as we found issues with storage, administration, records and staff training. The home used an electronic system for recording medicines administration, (eMAR). Staff could use one of four hand-held devices to check what medicines were prescribed. Medicines were stored securely in people's bedrooms and could be administered and recorded on the device.

We spoke with one nurse who had worked at the home for four months and knew how to use the system but had not received any formal training. We found records were not secure as user names and passwords had been saved on the system log in. This meant that the person administering the medicines could not always be correctly identified.

We checked the stocks of 26 medicines against the electronic record and found discrepancies with nine medicines. This meant some medicines had not been administered as recorded.

We looked at the eMAR for 41 people in the home and looked at 20 records in detail. We found 11 people did not have a photograph in their record to help staff identify them. One person had refused consent to having their photograph taken. Five people did not have an allergy status recorded, which meant there was a risk they could be given something they were allergic to. We raised this during the inspection and staff took action immediately.

Additional information to guide staff how to look after people had not been added to the eMAR system. This meant staff were not alerted if people usually received their medicines covertly, hidden in food or drink, or how this should be done.

Personalised information for people who were prescribed medicines to be taken "when required" had also been excluded from the eMAR system. For example, some people were prescribed more than one laxative medicine and there was no guidance for staff to know which one to give. There were paper records kept, explaining how to give "when "required medicines", in a file in the staff office, but the details were not

specific and not accessible when staff administered medicines in people's bedrooms.

We found medicines that should be taken before food were often given with other medicines at breakfast and some administration times varied between 8.30am and 11.30am. There was a risk that these medicines would not be effective if not administered on an empty stomach as prescribed. Staff were unaware of the instructions for one medicine that can be harmful if not administered properly.

Twelve people were prescribed a powder to thicken their drinks because they had difficulty swallowing. The home did not manage these safely. There was insufficient stock for each person and staff told us they were sharing the remaining supply, despite people being prescribed different brands of thickener. Staff requested additional supplies from the GP and we were told this had arrived by the end of the day. Information was difficult to find and unclear regarding the consistency each person required. Information for care staff was created after the inspection however, there were errors in this documentation that had to be escalated to managers. In addition, we found no records were kept when thickener had been added to a drink and eMAR's were incomplete. People were at risk of choking if drinks were given that were the wrong consistency. This has previously been an issue in this home.

Medicines were stored securely in a treatment room on the first floor. Recorded temperatures demonstrated the room and fridge was in range however, readings were not done daily and the minimum and maximum fridge temperature was not recorded in line with the homes' medicines policy. Where medicines were stored in locked bedroom cupboards, the home had no assurance that medicines were kept below 25°C following manufacturers guidance.

The Medication policy for the home did not include using the eMAR system despite being updated in June 2018 so staff were not able to refer to this document and were not following the current policy by using the system. Evidence of annual medicine staff competencies was not provided, and managers planned for these to be completed after the inspection. Some medicines audits had taken place but had failed to identify the issues we found at this inspection. Actions were taken immediately following the inspection to address the issues found, but there were still concerns regarding registered managers' oversight and consistency throughout the home. The shortfalls above meant that people could not be assured they would receive their medicines safely from staff who were competent.

This meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment checks were carried out before staff started working at the home. We looked at the personnel files of six members of staff that we were told had been recruited to the service since the last inspection in 2016. Whilst all of these files contained completed application forms that included some reference to their previous health and social care experience, their qualifications and employment history, five of the six files contained references that were of poor quality. These references were from friends, neighbours or close associates of the applicant and the service had not taken steps to ensure that references were obtained from former employers especially those employers involved in health and social care as is required by regulations.

One of the personnel files we considered was of particular concern as a member of staff had disclosed on their application matters that meant that they may not be suitable to work with vulnerable people. The provider had failed to ensure that appropriate checks were completed to enable them to make a decision about the person's suitability to be employed at the service including contact with the Disclosure Barring Service (DBS) to establish if the person was barred from working with vulnerable adults.

The suitability of the employment of this staff member was questionable and the matter was immediately brought to the attention of the registered manager. The registered manager immediately commenced checks and advised that the member of staff would not be engaged in the service until all checks had been completed.

There was a failure to recruit staff in a robust manner. This was a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they had no concerns about their safety at Andrew Smith House. All people we spoke with told us they felt safe and secure with the care they received. Comments people made to us included, "I feel safe here and I would speak to [name removed the manager] if I didn't feel safe for any reason. I don't know what a complaint is. My meds are fine here and its nice and clean. I like to sit here and look at people coming in and going out.", "I feel safe here and I like living in this home. A relative commented, "Yes, having lived here for three and a half years I can say with confidence that my [relative] is safe here." And "It's clean here and the staff are generally very good."

The registered provider had procedures in place to minimise the potential risk of abuse or unsafe care. Some staff had received safeguarding training. We saw records of safeguarding enquiries and alerts that had been completed. Evidence we saw demonstrated that care staff were able to report concerns if they suspected people were at risk of exploitation or harm. Safeguarding procedures had been reviewed regularly and information on how to report concerns was readily available in the home. This meant people living and working in the home were familiar with the safeguarding procedures. In addition, a member of the staff team was appointed as the safeguarding champion. They attended the local champion's forum. They told us information from this forum was disseminated to both staff and people who used the service. One staff member told us, "We have a duty of care to report any form of abuse and we are encouraged by the manager to whistle-blow or report any concerns externally."

Staff had completed relevant training and had access to a set of equality and diversity policies and procedures. We also noted people's individual needs were recorded as part of the support planning process. This helped to ensure all people had access to the same opportunities and the same, fair treatment.

Before this inspection we had received concerns about staff shortages. We looked at the staffing rotas and found a designated senior staff member or nurse was in charge of each unit with supporting care staff throughout the day and at night. Domestic staff worked five days each week. The service had recruited two activities staff and a minibus driver. Any shortfalls due to leave or sickness were covered by existing staff or agency staff. We noted that staffing levels needed to be reviewed in one of the units where people's needs had increased. We also noted there were times when staff had struggled to manage safely due to the staffing levels in that unit. We shared our findings with the registered manager and the director of the service who informed us they would take action to increase the staffing levels. This would ensure that the unit has adequate numbers of staff to monitor people and respond to their needs.

People made positive comments about the cleanliness of the service. We noted that the registered manager had completed weekly walk arounds to inspect the cleanliness of the home. Any concerns they found had been clearly communicated with the domestic staff and time scales had been agreed for rectifying the shortfalls. There were infection control policies and procedures for staff to refer to and staff had been trained in this area. An infection control champion had also been identified to share best practice in this area. Staff were provided with protective wear such as disposable gloves and aprons and suitable hand washing facilities were available to help prevent the spread of infection. There were contractual arrangements for the safe disposal of waste.

There were systems to manage the safety of portable appliances, electrical devices and to ensure that water in use at the home was safe for consumption and within safe operating temperatures. Equipment such as hoists, wheelchairs, mobility aids and lifts were also serviced regularly to ensure they were functioning correctly and safe for use. We noted that all of the hoists and wheelchairs had been checked for safety and serviced by a specialist contractor on an annual basis.

We noted that senior staff from the provider's head office conducted environmental safety checks every month and these included a review of the weekly fire safety check and their own checks on the fire alarm system. This meant that full and thorough checks were taking place to ensure that people were not put at risk from fire.

Training had been provided to support staff with health emergencies, fire safety and the safe movement of people. We observed people being supported safely and appropriately during the inspection; we observed staff offering reassurance when needed.

A business continuity plan was in place to respond to any emergencies that might arise during the daily operation of the home. The environmental health officer had awarded the service a five star rating for good food safety and hygiene practices. There was key pad entry to enter and exit the home; visitors were asked to sign in and out which would help keep people secure and safe.

Requires Improvement

Is the service effective?

Our findings

We looked at how the service trained and supported their staff. Records showed that staff completed an induction when they joined the service. They had received supervision and appraisals. Some improvements were required to ensure staff received supervision in line with the provider's policy and to ensure supervision was provided by staff who had the right skills and knowledge. Staff had also received national vocational qualifications. However, we found significant shortfalls in the training provided in the home. Staff had not completed training that the provider had deemed necessary for their roles. For example, 83 care staff had not completed training in the prevention and control of infections, 25 staff had not completed training in the safeguarding of adults, 26 did not have up to date mental capacity training. We also found 52 staff did not have up to date fire safety training. Medicines management training had been provided however to senior staff and nurses only. The organisations' training policy stated that all staff were to receive medicines training. We noted that staff had signed training agreements which required them to complete the training required for their role.

We also noted that the internal inspections carried out by provider did not include checks on whether staff were completing training as required. This meant that the provider had not adequately monitored whether staff were keeping up with the training they were required to undertake. This meant that people could not be assured they would receive effective care from a staff team that were skilled and knowledgeable. We spoke to the registered manager who informed us that staff had been reminded to attend training however, this had not happened. The provider and the registered manager are responsible for ensuring their staff have up to date training.

There was a failure to ensure that all staff had received such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people we spoke with gave us positive feedback about the caring approach from the staff. Comments from people included; "The staff here know how to support me. They manage things for me including when I need to see my nurse", "The staff don't do very much for me, so don't need to ask for my consent very often" and, "They support me with everything that I need; I'm much better in here than before; that's what my family think as well."

Comments from relatives were positive, they included; "Care staff are generally good and have the necessary skills", "The care plan that we have in place is followed. The optician visits my [relative] regularly."

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 or 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of the MCA. The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff told us they understood the importance of gaining consent from people. Where people had some difficult expressing their wishes, they were supported by their relatives or an authorised person such as an advocate. Some consent records had been completed in relation to medicines management and health observations.

When we undertook our inspection visit a significant number of people who lived at the home had DoLS authorisation requests submitted to the local authority and some had been authorised. The registered manager was regularly checking the progress of the other applications. However, improvements were required to show whether mental capacity had been considered before DoLS applications were submitted. This was because we found mental capacity records were missing in three of the records we reviewed. We discussed this with the registered manager and they informed us that they would complete the relevant documentation and that some had been done and misplaced. We also observed that they had involved other professionals to determine people's best interests.

The environment had been adapted to a high standard to meet the needs of people living at Andrew Smith House. Adequate living space was provided and furnished to help maintain people's safety, independence and comfort. We found each section of the home had been decorated to meet the needs of people living in the different parts of the home. For example, the kitchen in the young adult's section had been designed to ensure people wishing to maintain their independence could easily access the kitchen with mobility aids where required. The unit where people living with dementia resided was adequately decorated to meet the requirements for a dementia friendly environment. This helped orient people to their environment. We noted appropriate signage was in place throughout the home and there were crafts, photographs and creative posters with inspiring words displayed on the corridor walls. Some areas of the home had been redecorated and ongoing plans to refurbish the home were in place including ongoing maintenance work and repairs.

We checked one bedroom and found it had been decorated to the persons' taste. The majority of the bedrooms were decorated to people's tastes and a homely environment had been created with personal items such as furniture, photographs, posters and ornaments. This promoted a sense of comfort and familiarity. Each individual was provided with a lockable cupboard for their medicines or personal valuables.

Staff told us communication was good. Regular handover meetings, handover records and communication diaries kept staff up to date about people's changing needs and the support they needed. Records showed key information was shared between staff and staff spoken with had a very good understanding of people's needs and the management of the home. However, as noted in the 'safe domain', communication about significant incidents was not always effective to assist learning and risk reduction.

Staff completed a range of assessments to check people's abilities and review their support levels. They checked individual's needs in relation to safety, mental and physical health and medicines. Specific requirements for each individual had been identified. For example, people who required assistance with pressure care, wound care, soft diet, and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who stayed at the home.

There was a variety of choice for people. We observed there was a menu with choices for people. People

with special dietary requirements were supported to ensure their needs were met. We saw one person had met with the registered manager to discuss their dietary needs and had regularly provided feedback on the quality of the meals. People told us, "The meals are alright, it tends to be a little spicy at times", "I enjoy the meals and we all have a choice of two main meals." We spoke to the registered manager about the comment on the food and they informed us they had met with the person and ensured they communicate their preferences to kitchen staff. There were initiatives for promoting healthy life styles such as the benefits of healthy eating. People confirmed they were offered meals of their choice, including meals that met people's religious requirements where this was required. People had been involved in the menu planning and told us they received plenty to eat and drink.

During our visit, we observed lunch being served across different parts of the home. We observed people enjoyed their meals. The meals looked appetising and the portions varied in amount for each person; some were provided with extra helpings on request. We noted that some people could have benefitted from utensils such as plate guards to assist them in their eating. We discussed this with the registered manager and the deputy manager and they took immediate action to ensure those that required these utensils were assessed. This would enhance people's dining experience and may help increase their nutritional intake.

Information about people's dietary preferences and any risks associated with their nutritional needs was shared and maintained on people's care plans. Staff were aware of people who had special dietary needs such as a soft diet. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how people were supported with their healthcare needs. People's care records included detailed information about their medical history and any needs or risks related to their health. Appropriate referrals were made to a variety of healthcare agencies. District nurses and speech and language therapists regularly visited people to review their health needs. People considered their health care was managed well.

Appropriate information was shared when people moved between services such as transfer to other services or admission to hospital. The home had been part of a pilot scheme with the local clinical commissioning group on the use of 'secure red bags' for sharing hospital transfer records also known as hospital passports. This was an initiative to improve the way services shared people's records and to reduce the risk of records going missing during a transfer between care homes and hospitals. Hospital transfer records are documents which promote communication between health professionals and people who cannot always communicate for themselves. The records we saw contained clear direction as to how to support a person and included information about whether a person had a DoLS in place, their mobility, skin integrity, dietary needs and medicines. The records also provided information about whether the person had a 'do not resuscitate order' (DNACPR) which is a legal form to withhold cardiopulmonary resuscitation (CPR). This meant other health professionals had information about individuals care needs to ensure the right care or treatment was provided.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information. This also enabled people to have on-line contact with families and friends. There was also an up to date website where information was shared about the service, activities and any updates on progress and planned developments. Staff utilised social media to share the activities they undertook in the home. We also noted the service used telemedicine to help staff seek medical advice remotely. 'Telemedicine' is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities or out of hours. The provider had

an electronic care records system. Staff had been provided with computers and hand held devices for inputting details of the care they provided. CCTV was available covering inside building and on the perimeter of the building to ensure people's safety. Relevant consent had been sought regarding the use of the CCTV.

Good

Is the service caring?

Our findings

People told us they were treated with care, respect and kindness and they were complimentary of the support they received. The feedback from people and visitors was overwhelmingly positive. Comments from people included, "The staff all seem kind and they treat me with respect. They particularly show respect for my privacy and dignity when they are using the hoist. They make sure that I am comfortable and covered during the process. It's very difficult to be independent when you can't move around as usual.", "It all seems quite good in terms of staff being kind and caring.", "The staff are all kind. If I ask them for any drinks they'll always bring them to me. They respect my privacy, for example, they always close the door if I am in the bath or shower."

Similarly comments from visitors were positive. Comments included "Absolutely, the staff are very caring and kind. They listen and seem to support [my relative] very well." One health care professional said, "Andrew Smith House is always a pleasure to ring and visit. Staff are caring."

The overall atmosphere in the home appeared happy, calm and peaceful. We observed good relationships between staff and people living in the home and overheard banter, laughing and encouragement during our visit. We observed staff interacted in a caring, friendly and respectful manner with people living in the home. Where people needed to be re-directed, this was done in a sensitive and calm manner to prevent any distress. People confirmed there were no restrictions placed on visiting and we saw relatives visiting as they wished.

We observed people were treated with dignity and respect at all times and without discrimination. People told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter during the inspection. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. In their PIR the registered manager wrote, 'The people who live at Andrew Smith House are the primary focus of everything that we do. They direct the service in a number of ways and one of our keys aims is to strive for excellence in caring so that those who live here are treated with kindness and compassion and their dignity and diversity is respected. This is achieved through, the company adopting a 'no uniform' policy to create a home from home experience and that everyone is on an equal level with no clinical barriers.'

People were encouraged to maintain their independence and to develop new skills. They said, "They react quickly to anything that I may need or ask for. They also help to promote independence." And, "I can go out anytime I want." We also noticed people were encouraged to do as much as they could for themselves and staff only intervened when it was necessary. This helped people to continue maintaining their independent living skills.

People were dressed appropriately in suitable clothing of their choice. People also confirmed there were no rigid routines imposed on them that they were expected to follow. We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills. For example, people were

supported to maintain their relationships and visit their local community on their own where possible. One person told us, "I'm very independent I can go out and about on my own and manage my own time."

From our discussions and observations it was clear staff understood the importance of acknowledging people's diversity, treating people equally and ensuring that they promoted people's right to be free from discrimination. For example we observed saw one person's family had requested that staff should not be present when they visit their relative in their bedroom to allow then to have privacy. The person was on one to one supervision at all times. Staff had respected this requested ensured privacy was protected. People's preferences with regard to being cared for by male or female staff were recorded. People's ethnicity and sexual orientation was recorded in their care documentation, this meant people's needs would be fully met in line with their ethnicity or sexuality. Information about people's spiritual or religious needs had been recorded in their care plans and there was a diverse staff team which reflected the diverse backgrounds of people who lived in the home.

People were encouraged to express their views by means of daily conversations, completing satisfaction surveys and at residents' meetings. The residents' meetings helped keep people informed of proposed events, enabled them to have a say about their food and gave people the opportunity to be consulted and make shared decisions.

Useful information was displayed on the notice boards and along the hall ways. This informed people about how to raise their concerns, any planned activities, events in the local community and any changes in the home. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

Requires Improvement

Is the service responsive?

Our findings

People who lived at Andrew Smith House gave us positive comments about the staff team and the care and support they received at the service. All responses regarding life in the home were positive and people shared with us details of the various activities and ventures they undertook. Comments from people included, "I have lots of hobbies, for example, I like knitting jumpers and doing tapestries. I love Northern Soul music and have some CDs here.", "I like some of the activities. We have an activities' coordinator and an activities' room. There is a programme of activities on the noticeboard that they usually follow.", "The staff like to take me shopping sometimes, which is good. There is a minibus too for trips out."

Relatives shared positive comments about life at the home. Comments included, "My [family member] seems to enjoy Tuesdays, when they do a lot of painting and craft work. [Family member] also like the knitting sessions here."

There was a strong emphasis on providing and supporting people with a variety of activities of their choice. We saw people had been supported with crafts arts, music and local trips. One person told us, "I like some of the activities." We saw examples of art and crafts that people had completed to thank their staff. The provider had purchased a mini bus for people to use. In their PIR the registered manager wrote, "A range of therapeutic activities, outing and events are planned throughout the year and displayed in various places in the home, so all of the people who live here are aware." This meant people were able to engage in meaningful and enjoyable activities both inside and outside the home.

In the majority of cases people's needs were carefully assessed before they moved into the service. However, we found one case where one person's needs had not been adequately assessed to determine whether their needs could be met in the home. We discussed this with the registered manager and they informed us this was an emergency placement. A robust pre-admission assessment would ensure that the home and staff were able to meet people's needs before they decided to admit the person into the home.

There were systems in place to ensure staff could respond share information about people's changing needs. This included a handover meeting at the start and end of each shift and the use of communication diaries, notice boards and handover sheets. In addition, staff had involved professionals such as GPs when they felt the need to do so. In some cases details of the reviews and any changes to the treatment were included in most of the care files. However, we noted that the registered manager and the provider were not always effectively responding to emerging risks which led to further incidents and injuries to one person. We noted in one file there had been five incidents of injuries and serious incidents however there had been no review carried out in relation to this person's needs. We found staff had recorded, 'no change' in the person's record regardless of the incidents. This meant that these incidents had not been reviewed to determine the best way of reducing the re-occurrences. This meant the provider was no always responsive to ensure changes were monitored to prevent further deterioration.

People were supported to maintain local connections and important relationships and to have an active social and economic role in their local community. During the inspection, we observed some people leaving

the home independently to attend their own social commitments in the community. Some people were accompanied by staff to visit the local shops. We observed other people relaxing and chatting to staff, visitors to the home or each other. This meant that people were supported to live as they wished, helped to reduce social isolation, stigma and enhanced people's well-being and feeling of self-worthiness.

We noted the provider had responded to the spiritual needs of the people in the home and their staff. They had provided a multi faith prayer room for people to use if they wished to pray or mediate.

We checked how the provider ensured that people received personalised care that was responsive to their needs. The care plans were well written, comprehensive and person centred. Each care record contained a detailed personal and medical history. There were details of each individual's likes and dislikes as well as signs and symptoms for staff to look out for as an indication of when a person's health started to deteriorate. Best approaches to support people in the event of behaviours that could challenge others was also at hand in the event staff needed to use them. The care records had been developed, where possible, with contributions from each person and their family. They identified what support each individual required. People told us they had been consulted about support that was provided before using the service.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted that people had communication care plans which detailed how they were supported to ensure they can communicate with others. Information was available in the home in different formats. One relative gave us an example of how people were supported. They said, "They show films and [relative] has talking books and a talking newspaper, the Nelson Leader. The library service visits so that talking books can be ordered and changed." In their PIR the registered manager said, 'For example a person living here with autism struggles to understand what is going on around them. The team tailored a visual communication chart using simple to understand picture descriptors with one word explanations to clearly identify key pieces of information that are important to them. This has been cascaded throughout the team looking after this person to ensure consistency and promotes an enhanced communication theme with a person living with a learning disability".

This demonstrated that the service had considered ways to ensure information was accessible to people. We noted some posters in the home were written in an easy read format. We would now expect the provider to incorporate the practices into their policies to ensure consistency.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. We noted there was a complaints procedure displayed in the entrance of the home and included in the service user guide pack. We saw two complaints made about this service. The complaints had been dealt with in line with regulations and measures had been put in place to address the complaints satisfactorily. We also saw examples of responses that had been prepared by the registered manager following people's complaints. People told us they were able to discuss any concerns during resident meetings; they told us they were resolved in a timely way.

We received a significant number of compliments from relatives before this inspection and saw some of the compliments received by the registered manager. Compliments included, "Thank you to [name removed] and the team for their outstanding care of [family member] during her recent poor health. We couldn't have asked for better care, massive thumbs up." We also received positive compliments from student nurses who

had been supported by staff at Andrew Smith House during their training.

The provider and the registered manager had gone above and beyond their duty and established a memorial garden at the service. This enabled people who had lost their family member to have a focal point to visit, reflect and share memories of their loved one. This showed the provider had taken into consideration the need to support people with their loss and grief.

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example, there was a policy which guided staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. Each person had been offered a 'preferred priorities of care document' also known as an advanced care plan. The preferred priorities for care is a document for people to write down what their wishes and preferences are during the last year or months of their life. Some of the care staff had received training in supporting people towards the end of their life. The service was working closely with the local clinical commissioning group in this area and they had received a significant amount of praise for the quality of their end of life care practices. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death. However, we noted that not all staff had received up to date end of life training. The registered manager assured us that this training would be arranged. This would demonstrate that staff were supported to develop their knowledge, skills and confidence to deliver end of life care.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager employed at Andrew Smith House. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at how the provider demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. We found there was an established system to assess quality of care and the maintenance of people's wellbeing. There was an internal inspection programme carried out by the provider's compliance department. This followed the CQC style of inspections. We found since our inspection in 2016, there had been internal compliance checks carried out by the provider. During the providers' management meetings, we noted they identified shortfalls in staff training in September 2017. However, we found these concerns were not addressed at the time of our inspection. This meant that there was a delay in ensuring that shortfalls to the safety standards were rectified in a timely manner. In addition, we noted that the audit checks carried out were not up to date with current regulation which did not fully support the registered manager and the staff to comply with regulations.

We saw that audits had been undertaken in various areas such as medicines, infection prevention and control and health and safety. We found systems for recording accidents and incidents were not robust as incidents were recorded in each person's individual file. There was no overall record of incidents in the home. This would be important to show the frequency and nature of incidents that had happened in the whole home and to identify any themes and patterns to establish measures for reducing them. This lack of analysis meant that we found a significant number of incidents that had been recorded with no evidence to show what had been done about them, especially where the incidents were repeatedly involving the same people.

Before this inspection, there had been an incident of choking in the home. While some people we reviewed had well written risk assessment in relation to this, we found practices in the home in relation to choking were not robust. For example, systems for managing thickening powders were not robust and in one unit one person identified to be at risk of choking had not been fully supported due to staffing levels which had led to an incident of choking. This meant that the systems for improving practices and care delivery through lessons learnt were not effective.

The audit systems were inadequate and not robust to enable the registered manager and the provider to learn from shortfalls and to take immediate action where people's safety was compromised. For example, we found the care audits had failed to identify that one person had experienced five incidents where there had been the potential for harm. They had not identified that there was no risk assessment and that no reviews had been undertaken following these incidents.

The medicines audits carried out were not accurate or reliable. The audits had failed to identify the shortfalls that we identified in relation to medicines management. For example, we found medicines audits

did not take into consideration the storage of medicines in the home, staff competences in medicines administration and a lack of records of allergies, among other shortfalls. We also found shortfalls in staff recruitment practices which had not been identified by the audits. This meant that the registered manager and the provider had failed to assess, monitor and drive improvement in the quality and safety of the services provided.

Systems and processes for training, induction and supervision were inadequate and suitable training had not always been provided to staff to support the delivery of safe care.

We spoke to the registered manager and the director of the home regarding the failures above. They took immediate action to rectify some of the identified shortfalls. They further advised that safety of people in the home was their utmost priority. However, we would expect the provider to have robust systems in place to oversee the care provided and to act without our intervention.

At our last inspection Andrew Smith House was rated overall good and the home was compliant with all regulations however, at this inspection we found six new breaches of regulations. These findings demonstrated that there had been a decline in the quality of care people received. This meant that the governance systems and processes in place did not enable the provider to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at how the providers promoted a culture that encouraged candour, openness and honesty to support organisational and personal learning. We found there was a policy in relation to Duty of candour which guided staff to act in a transparent manner when things go wrong. This also set out a commitment for open and transparent practices in the home. However, we found there had been two significant incidents in the home where the regulation and policy relating to transparency had not been followed. Where serious incidents have occurred, providers must operate systems to allow them to share a step by step account of all relevant facts known about the incident in person and offer an apology. This should include as much or as little information as the relevant person wants to hear including further enquiries that they would make in relation to the incident. While there was a policy at the service we found this policy had not been effectively implemented and apologies had not been offered with explanations of what had gone wrong. This meant the provider had failed to follow their own policies and people could not be assured they would receive explanations of what had happened in the event of serious incidents in the home. We spoke to the registered manager about this and they informed us they had contacted relatives by telephone. They also immediately wrote letters to the family of the people involved. However, in one of the cases they informed us they had followed their legal advice not to write to the relatives.

The provider had failed to maintain duty of candour. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We received overwhelming positive feedback from people who lived at the home. Comments from relatives included, "The manager of this unit is friendly. [Name removed] pops in every morning to say hello. The staff talk to me here and it's generally good.", "The manager is approachable.", "Yes, [name removed] is very approachable and he usually listens.", "The manager is approachable, and everybody knows me quite well now.", "I do feel that I can talk to the manager. They are very nice and they listen. The staff seem to know me very well."

Visitors told us, [name removed, registered manager] checks that everything is OK with us on a regular basis. There seems to have been so many improvements since this manager arrived.", "This is a happy environment. My [relative]'s well cared for and any problems that arise seem to be sorted quickly. I can't remember any specific problems. This place really has helped to put my mind at ease, because I could no longer manage to support my [relative] at home.

A member of staff commented, "The manager is listening and willing will take action."

The organisation had maintained some links with other organisations. They worked with organisations such as local health care agencies, local pharmacies, social workers and local GPs. There was a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Andrew Smith House. Evidence we saw showed that professional advice was sought where staff had concerns about people's health.

The provider was informing the Care Quality Commission (CQC) of key events related to people who lived at the home.

The provider had displayed their previous inspection rating prominently in the home as is required by regulations.

We also noted that the staff and the registered manager had effectively utilised local initiatives with the local authority and local clinical commissioning groups in areas such hospital discharge schemes and trainee nursing associate opportunities. They offered work placements to student nurses. We also noted that the provider and the registered manager had been given recognition for their contribution to local best practice initiatives such as the red bag scheme. These initiatives are promoted by the local authority and local clinical commissioning groups to share best practice and to improve the way services meet people's needs and introduce preventative measures. This meant that the registered provider and the registered manager had considered best practice designed to improve people's outcomes.

We checked how people who used the service, the public and staff were engaged and involved in the running of the home. We spoke to three relatives who informed us that they felt they were involved in the running of the service. They advised that they had attended meetings to discuss progress or the care that their relatives received. In addition, there were staff meetings. Staff we spoke with told us they felt the registered manager worked with them and supported them.

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. Care staff had delegated roles including medicines management, catering and domestic duties. Each member of staff took responsibility for their role. However, improvements were required to show the registered manager was monitoring unit managers in the home to ensure they were undertaking their roles and to ensure people were receiving appropriate care that met their identified needs.

We looked at how staff worked as a team and how effective communication was maintained between staff members. There was communication about people's needs among staff and management. We found handovers were used to keep staff informed of people's daily needs and any changes to people's care.

Following the inspection, we spoke with the director of the service and they informed us they would be taking robust action to address all the shortfalls we identified. They also took immediate action to address some shortfalls relating to staff shortages and risks to people.

The registered manager and the staff in the home worked with us in an open and transparent manner during the inspection. They co-operated with all our requests for information and evidence. In addition, we found some of the staff we met and spoke to were committed to provide good quality of care.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to fully mitigate the risks to people's health and safety. This was because accident and incidents were not analysed and significant incidents had not been reviewed to ensure lessons were learnt. Risks associated with bedrails had not been adequately managed. Regulation 12 (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to operate an effective quality assurance system in order to improve the quality and safety of the service. Systems for monitoring and improving the service were not robust. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider had failed to ensure that robust checks had been undertaken to ensure staff employed were of good character. Regulation 19 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 20 HSCA RA Regulations 2014 Duty of

personal care Treatment of disease, disorder or injury	candour The registered provider had failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Regulation 20 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)