Elderly Care Home Limited

Avalon Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Avalon Nursing Home on the 17 and 18 July 2017. This was an unannounced inspection. Avalon Nursing Home provides nursing and personal care for up to 38 older people, some of whom are living with a dementia type illness. There were 27 people living at the home at the time of the inspection. In addition to living with dementia people had a range of complex health care needs which included stroke and diabetes. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Avalon Nursing Home is owned by Elderly Care Home Limited and is situated in Hampden Park in Eastbourne, East Sussex. Accommodation for people is provided over two floors with communal areas and a garden. There were two lounges; one was called the nursing lounge and the other the Dennis Cullen wing.

At the time of this inspection there was no registered manager in post. An appointed manager was in post who was also a registered manager for another service owned by the provider. They had submitted their application to register with the CQC. 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 and associated regulations about how the service is run. After the inspection the manager became the registered manager following an interview with CQC.

At a comprehensive inspection in August 2015 the overall rating for this service was Inadequate. At this time we placed the service into special measures. Seven breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. The provider sent us an action plan and told us they would address these issues by February 2016.

During our inspection in May 2016, we looked to see if improvements had been made. The inspection found that improvements had been made and breaches in regulation had been met. However, the improvements had not been fully embedded in practice and they needed further time to be fully established in to everyday care delivery.

Due to a high number of concerns raised about the safety of people, care delivery, deployment of staff and staffing levels we brought forward a scheduled inspection to November 2016. We found people's safety was being compromised in a number of areas and the home was rated as Inadequate and was once again placed into special measures.

This inspection found that improvements had been made across all areas of the service. However, these improvements were not, as yet, all fully embedded in practice and need further time to be fully established in to everyday care delivery. The breaches of Regulations 9, 11, 12, 17 and 18 were not fully met.

There was a commitment from the manager and staff to continue with the improvements that had already

taken place. The manager, provider and director acknowledged that this would take some time. They told us they wanted improvements to be fully embedded and would take their time to ensure this was done properly. Staff were now aware of their roles and responsibilities and had an understanding of the vision and direction of the home.

The quality assurance system, audits and checks had not identified all the shortfalls we found. Care plans did not consistently contain the detailed information staff needed to support people to meet their individual needs. However, the manager had a good oversight of what was required to ensure the service continued to improve and meet the regulations. Staff told us they felt supported by the manager, they could talk to her and raise issues at any time. They felt listened to and knew any concerns would be taken seriously and acted on.

Risks were not consistently managed safely. Systems were not in place to ensure people's pressure relieving mattresses were set correctly and people were placed at risk through poor moving and handling practices.

There were enough suitably qualified and experienced staff to meet people's needs. However, these were not always deployed appropriately to ensure people's needs could be attended to in a timely way. Recruitment procedures were not always followed to ensure staff were suitable to work at the home.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and any Deprivation of Liberty Safeguards (DoLS) applications had been submitted when required. However, there was no information about how people who lacked capacity were able to make decisions. There was no information about who could make decisions on people's behalf.

There was a training and supervision programme. Staff received regular and ongoing training, however, staff competencies had not all been assessed and safe care delivery was not consistent.

People were given choices about what they wanted to eat and drink. They were supported to eat and drink a variety of food that met their individual needs and preferences. However, due to staff deployment some aspects of the mealtime experience still needed to be improved.

Care was not consistently person-centred. There were not enough meaningful activities for people to participate in throughout the day. People spent periods of time when they were unoccupied and unstimulated.

People were treated with dignity and respect. Staff were kind and caring. They knew people well and treated them with patience and compassion. We observed positive interactions taking place and people were supported to make their own choices.

People were supported to have access to healthcare services when they were needed them. There were systems to ensure people received their medicines safely, as prescribed. Staff had a good understanding of what steps to take to ensure people were protected from the risks of abuse.

The manager was working hard to develop an open and positive culture. This was focussed on ensuring people received good person-centred care that met their individual needs. The staff told us they felt supported and listened to by the manager. They understood the vision and direction of the home and the need for continued improvements.

We found a number of breaches of the Regulations 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. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Avalon Nursing Home was not consistently safe. Improvements had been made; however the provider was not fully meeting the legal requirements that were previously in breach.

There were enough suitably qualified and experienced staff to meet people's needs. However, these were not always appropriately deployed.

Risks associated with pressure damage were not consistently managed and people were placed at risk through poor moving and handling practices.

Recruitment procedures were not always followed to ensure staff were suitable to work at the home.

Medicines were managed safely.

Staff had received training in how to safeguard people from abuse.

Is the service effective?

Requires Improvement

Avalon was not consistently effective. Improvements had been made; however the provider was not fully meeting the legal requirements that were previously in breach.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. However, there was no information about how people who lacked capacity were able to make decisions.

There was a training and supervision programme in place. However, staff competencies had not all been assessed and safe care delivery was not consistent.

People were given choices about what they wanted to eat and drink. They were supported to eat and drink a variety of food that met their individual needs and preferences. However, aspects of the mealtime experience still need to be improved.

People were supported to have access to healthcare services when they were needed them.

Is the service caring?

Good

Avalon was caring.

People were supported by staff who were kind and caring. They supported people to maintain their dignity and respected people's privacy.

We observed positive interactions taking place and people were supported to make their own choices.

Is the service responsive?

Requires Improvement

Avalon was not consistently responsive. Improvements had been made; however the provider was not fully meeting the legal requirements that were previously in breach.

Care plans did not consistently contain the detailed information staff needed to support people to meet their individual needs.

Care was not consistently person-centred. There were not enough meaningful activities for people throughout the day. People spent periods of time when they were unoccupied and unstimulated.

Is the service well-led?

Requires Improvement

Avalon was not consistently well-led. Improvements had been made; however the provider was not fully meeting the legal requirements that were previously in breach.

The quality assurance system had not identified all the shortfalls we found. People's care plans did not include all the information about the care people needed or received.

The manager was working hard to develop an open and positive culture. This was focussed on ensuring people received good person-centred care that met their individual needs.

The staff told us they felt supported and listened to by the manager. They understood the vision and direction of the home.

Avalon 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 was an unannounced inspection on 17 and 18 July 2107. It was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the action plan sent to us by the provider following the last inspection. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records four staff recruitment files, training and supervision records, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at eight care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with eight people who lived at the home, nine visitors and twelve staff members including the manager. We also spoke with the provider and director who were present for part of the inspection. We observed the care which was delivered in communal areas to get a view of care and support provided across all areas, this included the lunchtime experience.

As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two visiting healthcare professionals to gain their feedback about the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection in November 2016 we found that people's health safety and welfare were not always safeguarded. The provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not enough, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. This was a breach of Regulation 18.

At this inspection we found improvements had been made and the provider is now meeting this part of Regulation 18. However, these improvements were not, as yet, fully embedded in practice and needed further time to be fully established in to everyday care delivery. Although improvements had had been made, we found the provider was still not fully meeting all of the requirements of Regulation 12. We also found a further area that needed to be improved.

Although we found improvements were needed, people told us they felt safe at the home. One person said, "I'm safe, it's a very nice place to be," a visitor said, "My relative is safe, there's no mistreatment by staff."

Risks associated with pressure damage were not consistently managed. Risk assessments had identified people were at risk of pressure area damage. There was information in care plans about the support people required to maintain their pressure areas. This included information about pressure relieving equipment such as air mattresses. Air mattresses are set according to people's weight and this information was in their care plans. Staff told us these were checked regularly however, we found four mattresses which had not been set correctly. This could leave people at risk of harm because their pressure areas were not consistently protected. We raised this with the manager who took immediate action.

People had not been consistently protected from avoidable harm due to inappropriate moving and handling procedures. One visitor told us, "Moving and handling is a bit iffy sometimes." We observed one occasion when a person was placed at risk of injury from a poor moving and handling procedure. They were being supported to move from the chair to a wheelchair. Two staff helped the person to stand by holding under the armpits. The brake to the wheelchair had not been applied and the wheelchair moved backwards as the person was seated. The two staff then lifted the person back in the wheelchair by holding under their armpits and thighs. Supporting people using this lift is dangerous. It can result in an injury to the person lifted, such as dislocated shoulders and bruising. There is risk of injury to the care staff undertaking this move such as a back injury. Not applying the brakes to the wheelchair meant the wheelchair was at risk of moving as the person was sitting down. This would have left both the person and staff at risk of falling and sustaining serious injury.

Some people were at risk of falls and had sensor mats by the bed. These would alert staff if people stepped on them whilst getting out of bed. Staff would then attend the person to support them safely. There were room charts which staff completed each time they went into the person's room. They signed the chart to show that people's call bells were accessible, sensor mats were in the correct position and working. We found the charts had been completed, but did not always reflect what we saw. Two charts stated that call

bells were accessible, however; we found they were hanging on the wall out of people's reach. For one person staff had recorded the sensor mat was in place, however, we found this had been moved under the person's bed. This meant people could not alert staff when they needed them, the lack of sensor mat meant staff would not be alerted if the person had got out of bed.

These above issues are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns we did observe instances of good moving and handling practice where people were supported safely and appropriately. People who were able told us they received the support they needed to move around. On the second day of the inspection pressure mattresses had been set correctly and call bells and sensor mats were in place.

People told us there were enough staff. Comments included, "I feel safe, there's always someone to call." "Generally they come quite fast when I call," "There are enough staff" and "When I call for help, it comes quickly." There had been improvements in the staffing numbers and deployment, however, further improvements were required to ensure this was sustained and fully embedded into practice. The home was divided into two units over the two floors. Staff were allocated into two teams to provide care. On the first day of the inspection staffing numbers were not as planned as there was no activity staff on duty. Therefore a member of care staff was required to stay in each lounge area to ensure people were safe which prevented them from providing care to people in their rooms. At lunch time two staff were supporting a person with their continence care. This meant and the mealtime experience in the nursing lounge was not efficient and some people waited longer than necessary to receive their meals. The allocation of staff was based on skill mix to ensure junior staff were supported by those more experienced staff. On the first day of the inspection this had not happened on the nursing unit and junior staff were working together. Staff told us this was how the work had been allocated that morning by the nurse in charge. Staff told us they had questioned this decision but it had not been brought to the manager's attention.

On the second day of the inspection all rostered staff were working. Staff were busy throughout the day and people were supported in a timely way. Staff were observed spending time talking and chatting with people. Staff told us there was not always enough staff on duty, when we asked for examples they said this was when not all rostered staff turned up for duty. There was minimal reliance on agency staff and as far as possible, regular agency staff were used to ensure people received care from staff they knew.

There was a recruitment system but this had not always been followed. Criminal records checks with the Disclosure and Barring Service (DBS) had not always taken place before staff started working at the home. For one staff member there was no risk assessment to demonstrate how the decision had been made or measures taken to ensure staff received constant supervision. The manager told us this staff member did not work unsupervised and did not have direct contact with people who lived at the home. For one staff member there was only one reference instead of the required two. There was no information about who had provided the reference or if it was a character or professional reference. We raised these with the provider as areas that needed to be improved.

Within recruitment records there were copies of relevant documentation application forms, and interview notes. Nursing and Midwifery Council (NMC) registration information had been recorded and there were regular checks to ensure nurses had maintained their registration with the NMC which allowed them to work as a nurse.

People were supported to receive their medicines safely. One person told us, "They give me my medication

and watch me take it" and another said, "I get my medication when I expect it." There was a system to order, store, administer and dispose of people's medicines. Where people had been were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or agitation. There were protocols for their use which meant people received medicines only when they needed them. Before giving these medicines staff asked and assessed people to determine if they needed them. MAR charts were well completed and regularly audited to identify if they had been any errors which would be addressed immediately. All nurses received medicine training and underwent competency assessments to ensure they had the knowledge and skills required to do so safely.

The home was clean and tidy throughout with no unpleasant odours. The environment was safe and doors marked as 'Fire door keep locked' were locked. The home was well maintained throughout with evidence of on-going work. Regular health and safety checks took place. These included environmental and fire checks, regular servicing for gas and electrical installations and lift and hoist servicing. The home was staffed 24 hours a day with an on-call system for management support and advice.

Following concerns raised previously, there had been a safeguarding plan by the local authority in place. The provider had worked with the local safeguarding team to address issues and ensure people were protected. At the time of the inspection there were no safeguarding concerns. Staff were able to identify different types of abuse and were aware of their responsibilities. They told us they would report any concerns to the senior person on duty, if this was not appropriate they were aware of reporting to external agencies such as the local Adult Services Safeguarding Team. The manager was aware of her responsibilities in reporting any concerns that may be considered safeguarding. Where concerns had been identified these had been referred appropriately to the safeguarding team for review.

Requires Improvement

Is the service effective?

Our findings

At our inspection in November 2016 we found that people did not receive care that was effective. The provider had not ensured that people received suitable and nutritious food and hydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not have individual mental capacity assessments in place and certain decisions had not been referred for a best interest meeting. This was a breach of Regulation 11. Staff had not received appropriate training, professional development and supervision to meet the needs of the people they cared for and this was a breach of Regulation 18.

At this inspection improvements had been made and the provider is now meeting the requirements of Regulations 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and needed further time to be fully established in to everyday care delivery. Although improvements had been made we found the provider was still not fully meeting all of the requirements of Regulations 11 and 18.

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

The MCA says that assessment of capacity must be decision specific and must also be recorded how the decision of capacity was reached. Mental capacity assessments had taken place but these were not always decision specific. Care plans did not always contain detailed information about how people could make decisions. Some people shared bedrooms and there was no information about how these decisions had been made or who had been involved. There were consent forms which demonstrated people had agreed to have their photographs taken or receive care. Where people lacked capacity some of these had been signed by their relatives. There was no evidence all relatives had the legal right to consent on the person's behalf. Some care plans stated people had power of attorneys but there was no record of what these covered. There were copies of some people's power of attorneys at the home but this was not consistently recorded in their care plans which meant not all staff would be aware.

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 whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been submitted for people who did not have capacity and were under constant supervision by staff. There were copies of the DoLS applications in people's computer records but care plans did not inform staff if a DoLS had been authorised or had been applied for. Some people were restricted from free movement by bed rails, the use of lap belts on wheelchairs or positioned in recliner chairs. Specific mental capacity assessments for people on how their freedom may be restricted or what

least restrictive practice could be implemented were not in place.

These issues are a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had an understanding of mental capacity and people's right to make their own choices. One staff member said, "It's not up to me what (the person) wears it's up to them. If they didn't make wise choices (the staff member described seasonal clothing) they I would guide them and encourage them to make a different choice."

When staff commenced work at the home they completed an induction. This included fire and moving and handling training, they were introduced to the daily running of the home, policies and procedures and people who lived there. They then spent time shadowing other staff before providing care unsupervised. A senior member of care staff, with appropriate skills, was responsible for ensuring care staff had the appropriate knowledge and skills to provide care and support. The manager told us there was a senior member of care staff who was responsible for assessing staff competency following moving and handling training to ensure they could support people safely and effectively. However, we observed an incident of poor practice in moving people. One staff member had their competency assessed during induction but there was no evidence available to demonstrate if the second staff member had received a competency assessment. Staff told us if they had not received a competency assessment they would work with more experienced staff but there was no evidence the experienced staff member had been assessed. On the first day of the inspection we also identified less experienced staff were working together. Following training staff had completed questionnaires, in relation to mental capacity and nutrition, to assess their level of learning. We saw a number of these questions had been answered incorrectly. We were told discussions had taken place with the some staff and further training would be provided. There was no overview of competency assessments. There was no information about who had had their competency assessed and whether they had the appropriate skills or needed further support. There was no analysis of the questionnaires to determine staff's individual knowledge or identify where further support was required and how this would be provided.

Staff received regular supervision and staff told us they were well supported by the manager. However, due to the lack of information about staff competencies and their knowledge the provider cannot be confident that supervision was effective as there was a lack of information about staff knowledge and skills which required support additional training.

This meant the provider had not ensured that staff had appropriate knowledge, skills and supervision to meet the needs of the people they cared for. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a training programme and the manager had oversight of what training staff had received and what was required. We saw further training was booked throughout the year. One person told us, "The staff seem well trained," and another said, "They know how to look after you." Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. Following this staff were signed up to complete a level two health and social care qualification to support their ongoing learning and knowledge.

Nurses received clinical training and competency assessments. There was evidence about where further training and competency assessments were required. We saw one nurse had completed further training and assessment to ensure they were able to give medicines safely. Where competency assessments had not

been completed there were plans to address this. For example, the nurses had not received recent catheterisation competency assessments. Therefore, if a person needed their catheter changing they would contact the manager who would support them and also complete an assessment. The manager told us, "I am aware of what's needed but I can't do the assessment until the situation arises."

We found improvements had been made to the mealtime experience to ensure people were supported to have enough to eat and drink to meet their individual needs and choices. However, we found further improvements were required to ensure this was sustained and fully embedded into day to day practice. There were systems in place to assist with the smooth running of the service and this was overseen by a senior member of staff. However, this was not effective on the first day of the inspection, in the nursing lounge. Activity staff would usually provide support to people at mealtimes and ensure the dining tables were appropriately set. There had been no consideration of how the mealtime could be managed due to reduced staffing numbers. Due to the poor deployment of staff, the mealtime experience for people was not enjoyable. People had been sat at the table for some time before lunch was served. The table had not been set so for people with dementia there were no visual cues as to why they were there. The meal table was then set with place mats whilst people were there. Only two staff were assisting with lunch which therefore took a long time. There were blackboards in the dining areas which staff filled in to show people what was on the menu each day. On the second day this had not been updated in the nursing wing which meant there were no visual reminders available for people about what was for lunch.

We did observe good practice in the Dennis Cullen wing and at other mealtimes throughout the inspection. People told us, "The food's wonderful and we get choice," "I like the food here" and "The food's not bad." They told us they had enough to drink, Comments included, "Yes, I definitely get enough to drink" and "I just ask for juice when I want it."

People chose where to eat their meals. Some sat at dining tables, with small tables in the lounge areas or remained in their bedrooms. One person said, "I choose to have my meals in my room." They were offered a choice of meal and this was offered at the point of service. This meant people were able to see and smell the food that was available which helped them to make their own choices. If people did not like what was on the menu then alternatives were offered and provided. People were provided with the support they needed to eat their meals. This included prompting and reminding, adaptive cutlery and one to one support. Where people required one to one support this was provided by one member of staff until the person had finished their meal. Staff engaged with people throughout the meal, they talked to them about what they were eating and made sure people were happy with their choice. There was a selection of soft and alcoholic drinks provided throughout the lunchtime.

Staff had a good understanding of what people liked to eat and drink and this was used to support people making choices. In the kitchen there was information about people's dietary likes and dislikes, it included how they liked their hot drinks for example with milk and/or sugar. It also included what people's breakfast preferences were. Nutritional risks were identified and acted upon. There was information about people's dietary needs which included diabetic, soft or pureed diets and the use of thickeners in people's drinks. There was guidance in place, staff had a good understanding of people's dietary requirements and this was followed appropriately. People were weighed regularly and this helped identify any risk of malnutrition. Staff recorded what people had eaten and drunk throughout the day. People's fluid intake was reviewed and printed out twice a day. This was used to ensure staff on each shift were aware of people who had not drunk enough and needed support and encouragement to drink more.

People received on-going healthcare were supported to maintain their health. Comments from people included, "If I'm not well, they get the GP in," "They organised a visit from the chiropodist" and "The GP visits

when I need him." Records demonstrated that staff regularly liaised with a variety of health care professionals to ensure people received appropriate healthcare. This included the tissue viability nurses, speech and language therapists, GP and chiropodist. The nurses maintained contact with the GP's and liaised with them regularly for advice for example if people's health needs changed. A visiting healthcare professional told us staff knew people well, they referred people to them appropriately and acted on the advice given.

Good

Is the service caring?

Our findings

At our inspection in November 2016 we found that people were not consistently treated with dignity and respect. Their privacy was not always protected. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider is now meeting the requirements of Regulation 10.

People and their relatives were generally positive about the care. They spoke about previous concerns but acknowledged there had been improvements made. One visitor said, "The care and system has improved in recent months." People's comments included, "Staff are very nice, I've never been refused care," "I've not seen or heard any harsh words by staff" and "Staff are kind, very nice people."

There was a good relationship between staff and people. Staff knew people well and had a good understanding of their individual needs, choices and preferences. People were supported to maintain and develop their independence as far as possible and encouraged to make decisions about their own lives. There was information in their care plans about how to support people to maintain their independence. Staff spoke to people with kindness and called them by their chosen name. They maintained eye contact and conversation when supporting them at mealtimes and when they were talking with them throughout the day. We saw positive interactions between staff and people and people were genuinely pleased to see staff when they came into the room. People were supported to maintain relationships with family and friends. One visitor told us, "There are no restrictions on visitors." They said they could visit whenever they wished.

We complimented one person on their appearance when they came into the lounge, this person was unable to respond verbally. The member of staff present explained the person was unable to choose their own clothes so they had supported them to dress appropriately. The staff member said, "It's important to look nice, and this really suits her, it goes well with her eyes." Another staff member spoke with us about choices. They told us, "I always give people choices but part of this job is thinking for people and helping them make choices when they are unable to make their own." They used their knowledge of people to help them make choices. This demonstrated that staff understood the importance of treating each person as an individual.

We saw staff supporting people to maintain their dignity. They adjusted people's clothing when they were sitting in a chair to ensure they were well covered. One person had removed their continence aid, staff observed this and attended to the person promptly. Another person had experienced an episode of incontinence and had declined staff offers to change their clothing. The staff member discreetly informed other staff what had happened so they were aware and able to offer the person the opportunity to change into clean clothing. Staff told us, "It's really not nice but we will keep offering and asking until we can help them change." We observed this was done sensitively throughout the shift.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in November 2016 we found people did not receive care that was person centred or that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made, however the provider was still not fully meeting all of the requirements of Regulation 9.

Since our last inspection a computerised care planning system had been introduced. People's care plans, assessments and risk assessments had been reviewed and updated. Although these had improved they were not always personalised and did not contain all information staff may need to look after people. Diet and fluid care plans stated people should have a healthy, low fat, low sugar and low salt diet. There was no rationale for this and no information to demonstrate this was the person's choice. People had targets for daily fluid intake. These were based on people's weight and did not take into account other factors such as people's general health. One person's target was three litres, this had not been achieved but on average drank just over one litre a day and appeared hydrated. Some care plans contained conflicting information. One person had a catheter which needed to be changed at the hospital, this was recorded at the beginning of the care plan. However, within the action part of the care plan there was guidance about how to change this catheter at the home. This could lead to confusion and the person may receive care that was not suitable for their needs.

Within the care planning system there were added attachments, these included letters from the GP and life history documents. However, information from these documents was not always added to the care plans. One person had diabetes and the care plan informed staff to see the attached letter to determine acceptable blood level ratios. This information had not been included in the care plan and the attachment was not available for part of the inspection. Therefore staff did not always have the information they needed to support this person appropriately.
We observed an occasion where staff were not responsive to people's needs. One person was shouting at another and telling them to leave the lounge. Although staff were present they did not intervene. They did not talk to the person to find out what the problem was, offer reassurance to the second person or attempt any distraction techniques. This meant people did not always receive the support they needed.

Life history information had not been completed for everybody but where it was the information had not been used to inform the care plans. There was some information about what people liked to do, their hobbies and interests. However, there was no clear plan about how people were supported to maintain these or enjoy meaningful activities during the day. Throughout the inspection people spent long periods of time unstimulated and with limited interactions.

On the first day of the inspection the activity staff were absent. Through the SOFI and general observations we saw two people in the nursing lounge who had been sat at a table for four hours. They had not been offered a change of position in the room to enable them to engage and interact with other people. In the

Dennis Cullen wing one member of care staff was involved in a 'pampering session' with people as there was no activity staff. People who were living with advanced stages of their dementia, were not involved in the session and received limited stimulation. Some people spent a lot of their time in the lounge unoccupied or sleeping.

On the second day there were two activity staff and we saw some engagement taking place. This included a game and a pampering session in the nursing lounge. In the Dennis Cullen wing activity staff was reading snippets of the newspaper and talking to one person. There was music playing but this was chosen by staff and we did not hear them asking people if that was what they would like to listen to. Activity staff told us there was one to one engagement with people who did not leave their rooms or participate in group activities. This was between 9 and 10am and usually included a chat or reading the newspaper. Between 9 and 10am people were getting up and having their breakfast. There was no information to say this was what people wanted or at this time. We saw a few occasions where staff were present in the lounge, and did not take the opportunity to engage with people or undertake any meaningful activity.

This evidence shows that although improvements had been made people had not received person centred care that reflected their individual needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we observed and were told about areas of good person centred care. One person said, "There's enough to keep me occupied," another told us "I love the musical entertainment." People who were able told us what they done each day. One person explained they liked to stay in their room but may go out depending what the activity was. We heard some people had music playing in their bedrooms. One visitor said, "They used what I told them about X, she likes the radio on, it gives her pleasure."

Some people told us they received the care and support they needed. One person said, "I get just the care I need here." Visitors also told us they were satisfied with the care their relatives received. One visitor told us, "I'm more than satisfied with her care here, it suits her." There was mixed feedback about people's and relatives involvement in care planning. One person said, "I feel I am involved in decisions about my care." Some visitors told us they had been involved in developing their relatives care plans but another said, "The staff don't involve me in her care plan but they do talk to me about her care." All relatives we spoke with told us they were kept up to date with any information that affected their loved one's care or support.

People who had been identified at risk of developing pressure damage had their positions regularly changed in line with their care plans. Staff understood the support people needed to maintain good skin care. People were supported to maintain their continence needs whenever they needed it. Those who could not express their needs were supported throughout the day. Staff told us, "Obviously if someone needs to use the toilet we take them, but for those who can't tell us we take them regularly throughout the day." They then described people's individual toileting routines. There was good information about people who had wounds. There was guidance for nurses about how these should be treated. The wounds were measured and described at each dressing change and regularly photographed to demonstrate the improvements made.

There was a complaints procedure in place. People told us they had no complaints but would be happy to discuss them with the manager if they did. One person said, "I've no grumbles at all" another, "If I was unhappy about something, I'd say so to the manager" and "I've not needed to complain about anything, although it took me a while to get used to how it all works here." Relatives told us they were happy to raise any concerns with the manager. One relative was talking to us about the previous concerns at the home. They said, "I've had no complaints recently, well actually I've had little grumbles, but I go straight to the

manager and it's sorted." We saw most complaints had been responded to appropriately. One complaint had been responded to but not all the issues raised had been addressed. We raised this with the manager as an area that needs to be improved. There was one complaint in progress at the time of our inspection.

People, relatives and staff had been asked for their feedback through quality assurance questionnaires. The feedback was in most cases positive and any issues raised had been responded to. The manager told us a few questionnaires were sent out regularly to help maintain an overview of the home and identify any areas of concern. People and visitors told us they regularly provided feedback to the manager as issues arose.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in November 2016 we found quality assurance systems were not fully completed and had not identified the shortfalls we found. People's records were not accurate and placed people at risk from inappropriate care. This was a breach of Regulation 17 of the Health and Social Care Act 2014.

At this inspection we found improvements had been made, however the provider was still not fully meeting all of the requirements of Regulation 17.

There was no registered manager in post. An appointed manager was in post who was also a registered manager for another service owned by the provider. They had submitted their application to register with the CQC. Following the inspection the manager became the registered manager after an interview with CQC.

In most cases feedback from people and visitors was positive. They told us leadership at the home had improved since the manager had been appointed. One person told us, "Very good management" another said, "I think its run very well." Visitors acknowledged previous concerns and told us they felt improvements had been made. One visitor said, "The management does seem a bit better now." Visitors told us they were pleased the manager was working at the home. Comments included, "We're glad X is back," "It's so much better now X is here." Another visitor said, "We are glad the manager has taken over and things have improved, but there is a way to go yet." Some people and visitors discussed concerns with us and these included some care concerns and issues related to the laundry. We discussed these with the manager who was already aware and told us what action was being taken to address them.

Quality assurance systems were in place and although they had improved, further improvement was required. They had not identified all the shortfalls we found, this included pressure mattress checks which had not identified incorrectly set mattresses. The provider had not identified that moving and handling competencies had not been completed. Where shortfalls had been identified these had not always been action taken to address. We first identified in August 2015 that where people shared bedrooms there was no information about how this decision had been made, there was no evidence of best interest meetings or any discussions having taken place. This still had not been addressed.

There was a new care planning system and this was taking time to be fully embedded into practice. Care plans and assessments still required more detail to ensure they fully reflected each person. Care plans had not been cross referenced to ensure staff had consistent information for example eating and drinking care plans reflect the same advice as diabetes care plans. Not all information had been analysed. Information about people's fluid intake was printed out twice a day and highlighted to show where people had not drunk sufficient amounts. This information was passed to staff at handover. We identified, from these print outs that some people had drunk large amounts. One person had drunk seven litres, daily notes stated that care staff had recorded 5000mls instead of 500mls. However, another person had drunk five litres and there was no information to identify if this was correct, if this was usual for this person or any other reason. The printouts had not been dated or timed so difficult to know when things had happened or what action had been taken.

There was a lack of consistent oversight throughout the day. We observed there had been poor deployment of staff and unsafe moving and handling processes. These had not been identified or addressed by staff.

Accident and incident records had been completed. There was information about what actions had been taken to prevent a recurrence and help keep people safe. However, we identified one complaint which highlighted issues that needed further investigation, this had not been done.

These issues show that people had not been fully protected against unsafe treatment by the quality assurance systems and this was a continued breach of Regulation 17 of the Health and Social Care Act 2014.

The manager was aware improvements were still needed to ensure the service was continually providing good quality care. The manager was also a registered manager for a sister home owned by the provider. She understood her responsibility to comply with the CQC requirements and was aware of the importance of notifying us of certain events that had occurred within the service. This was to ensure that we have an awareness and oversight of these to ensure that appropriate actions were being taken. The manager was aware of the duty of candour requirements following the implementation of the Care Act 2014. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided. The manager told us they kept themselves up to date through regular training and taking ongoing responsibility for various roles. This included a being a link nurse for tissue viability and had completed the mentorship course in 2016 through a local University.

She focussed on ensuring people received good person-centred care that met their individual needs. She knew people well and had a good understanding of their care and support needs as well as what was important to them. The manager worked at the home most days and was a visible presence when on duty. The manager was working hard to re-build relationships with relatives and visitors.

The manager had worked hard to improve the culture of the service and ensure improvements were embedded into everyday practice. Whilst this was evident throughout the inspection we also observed some incidents which demonstrated improvements were still required. Staff were allocated into two teams each day, we observed a staff member requesting help from a colleague. They were told, "We're not working on that side today." This did not demonstrate an open and inclusive culture.

Communication had improved and staff were updated about changes in people's needs at each handover. A handover document contained information about people who needed their position changed and the frequency. It also included the time of they were last moved and the position they were in. This helped to provide good continuity of care for people. There was a 'nurses' book which contained clinical information including health related conditions that may affect people.
There had been staff meetings where staff were updated about changes at the home and given the opportunity to feedback any comments.

Staff we spoke with told us there had been improvements at the home. They said this had been driven by the manager. One staff member said, "It's much better now X is here." Staff told us they could approach the manager at any time and felt well supported. One said, "I can go to her at any time." Another told us, "I can talk to her or the nurses at any time." One staff member said, "It's much better, before some staff seemed like they didn't care, that's changed now." Another staff member told us they enjoyed working at the home. They said, "It's a good team that love their work."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training, professional development and supervision. 18 (2)(a)