Complete Care Homes Limited

Rambla Nursing Home

Inspection report

374 Scalby Road
Scarborough
North Yorkshire
YO12 6ED

Tel: 01723500136

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Rambla Nursing Home provides personal care for up to 30 older people who may have nursing needs. The service is also registered to care for younger adults, people who are living with dementia and people whose needs are predominantly associated with physical disability. On the day of the inspection there were 29 people living in the home, 27 of whom required nursing care.

This inspection took place on 21 October 2016 and was a re-rating inspection carried out to provide a new rating for the service under the Care Act 2014 and to see if the registered provider and registered manager had made the improvements we required during our last inspection.

This inspection was also prompted in part by a continuing investigation into alleged serious shortfalls in care delivery to one person living at the service. This has involved the police, North Yorkshire County Council, Scarborough and Ryedale Clinical Commissioning Group and the Care Quality Commission (CQC). This matter is subject to an on-going investigation and as a result this inspection did not examine the specific circumstances of the allegations.

However, the information shared with CQC and other stakeholders, indicated potential concerns about the management of people using the service in relation to moving and handling and the risk of choking. This inspection examined those risks.

We last inspected this service on 7 and 11 April 2016 where we identified breaches relating to:

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to medicine audits which were not formally recorded; clinical monitoring charts which were not always completed accurately with no gaps to ensure people received the care they required; and, risk assessments which were not always clearly linked with care plans to provide a consistent plan for staff to follow when offering care.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 where one aspect of medicines handling was unsafe.

After that inspection the provider sent us an action plan telling us about the actions to be taken. During this inspection we found that some of the previous assurances from the provider had been implemented with some improvements made in relation to medicines audit.

However, at this inspection we also found breaches of five of the Fundamental Standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, person centred care, safeguarding people from abuse and improper treatment, staff induction, training and recruitment processes and the overall governance of the service. For example, unsafe manual handling and feeding techniques which had placed at least one person at serious risk were seen. Risk

assessments were not sufficiently detailed to mitigate identified risks. Staff recruitment was not robust and although systems were in place to assess and monitor the service, these had not been completed consistently.

Prior to the inspection a relative had provided us, the local authority and the provider with video footage showing round the clock care delivery to one person using the service. After the inspection visit and as part of our inspection CQC inspectors viewed this footage. They also considered the verbal accounts and views of what was seen on the footage from the local authority and police. We saw care practices by several staff members which raised serious concerns over staff supervision. Also, a clear need for registered nurses to lead other staff designations by example of best practice at all times. This also raised significant concerns about the registered manager's leadership and lack of action where care practices were unsafe and unacceptable.

As a consequence of this CQC has instigated their enforcement powers against the registered provider and registered manager. 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 home had a registered manager in post. 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.

The feedback we received from the majority of the relatives of people who used the service was positive. They were very satisfied with the quality of the service their relatives received.

Staff had received safeguarding adults training and were aware of the actions they needed to take if they had concerns regarding people's safety. However, the registered provider needed to ensure all staff had a comprehensive understanding of what constitutes abuse and poor practice.

There were general risk assessments in place relating to the safe running of the service and individual risk assessments for some people who used the service. However, the risk assessments relating to people lacked detail about mitigating against risk and failed to assess the balance between risk and people's independence.

Although there was no choice of menu people's food preferences were known and accommodated. People were very positive about the food provided with particular reference to everything being 'home cooked'. However, identified nutritional risks were not always appropriately managed.

Prior to people being admitted to the service an assessment was completed to ensure the service was able to meet the person's needs. There was a care planning format in place and we saw some good detail about people's needs, their likes and dislikes and their social history. However, these were not sufficiently personalised. Care plans predominately related to tasks to be completed rather than how to meet people's individual needs and choices; their well-being and enjoyment of life.

The registered provider did not have effective systems in place to monitor the care being delivered to people. We found record keeping was poor and management oversight at the service was not effective in ensuring people were provided with safe person centred care.

Improvements had been made to recording and auditing of the systems with regard to managing people's

medicines.

The provider followed the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions. This meant people's legal rights were protected.

Staffing levels were sufficient on each shift in order to meet their care and social needs.

People told us they were treated with kindness and were happy with the support they received. We found staff approached people in a caring manner and the majority were treated with privacy and dignity.

The registered provider had a complaints procedure. Some people were unaware of the procedure but told us they would feel confident in raising concerns with the registered manager. They also told us they felt they could talk with any of the staff if they had a concern or were worried about anything.

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.

There was clear evidence of unsafe manual handling and feeding techniques which had placed people at serious risk.

Staff had received training in safeguarding adults from abuse. However, further awareness training was required to ensure a comprehensive understanding of what constitutes abuse.

Risk assessments relating to individuals were not sufficiently detailed to mitigate identified risks.

There were sufficient staff on duty to meet the dependency needs of people living at the service.

There were inconsistencies in the recruitment process for some staff which increased the risk of employing unsuitable people.

Improvements had been made to systems to ensure people received their medicines as prescribed.

Is the service effective?

Requires Improvement

This service was not consistently effective.

People were provided with nutritious food. However, additional support to mitigate nutritional risks was not always in place.

Staff were unclear as to what factors they would consider when identifying weight loss. There was no policy available to manage weight loss and what action staff should take.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had received training and demonstrated understanding of the principles of the Act.

People had access to the local General Practitioner and district nursing services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Evidence of uncaring and undignified practice by nurses and care workers was seen on video footage.

People told us the staff had a caring attitude and that they were happy and satisfied with the quality of care received. People appeared at ease with staff.

At inspection we observed people's privacy and dignity was respected and staff were kind and attentive.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

People's needs were assessed prior to them being admitted to the service to ensure the service was suitable for their needs.

Care plans had been completed but they were task focussed and failed to include people's choices and preferences as to how they wanted their care and support provided.

Activities were available and reflected people's individual interests and preferences.

Relatives had opportunity to give feedback on the quality of the service and told us the provider communicated any changes in needs with them in a timely manner.

Is the service well-led?

Requires Improvement

This service was not consistently well led.

There was lack of robust oversight into the management and leadership of the service.

Evidence was seen of senior staff, including nurses, participating in poor and uncaring practice.

Although systems were in place to assess and monitor the service these had not been completed consistently, therefore shortfalls had not been identified and acted upon.

Staff said they felt supported by the registered manager and told us there was a culture of openness which took account of staff views.

Rambla 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 registered 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 21 October 2016. The inspection team consisted of two adult social care inspectors, who were supported by a specialist professional advisor (SPA). A SPA is a health and social care professional with a background relevant to the service being inspected. The SPA for this inspection was a registered nurse with experience of working with people at risk of malnutrition. An expert by experience also attended, they had personal experience of caring for older people.

Prior to, and following our inspection visit we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority and extensive CCTV footage provided to us by a relative. Before the inspection visit we spoke with one health care professional.

During the inspection visit we spoke with 17 people who lived at the home, three visitors, five members of staff and the registered manager. After the inspection visit we spoke with one health care professional and those professionals involved in a multidisciplinary safeguarding investigation. This included the police and officers from North Yorkshire Local Authority and Clinical Commissioning Group.

We looked at all areas of the home, including people's bedrooms where people were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at five sets of care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for six members of staff and two volunteers. We also observed the lunchtime experience and interactions between staff and people living at the home.

Inadequate

Is the service safe?

Our findings

Rambla Nursing Home has been in North Yorkshire County Council (NYCC) collective care safeguarding procedures since January 2016. Concerns have been raised in respect of the following areas; unsafe moving and handling, inadequate record keeping particularly in keeping an accurate record of people's food and fluid intake; failure to follow care and treatment plans as directed by health care professionals; failure to recognise care practices which were unsafe and which did not respect people's privacy and dignity.

Staff we spoke with confirmed they had completed training with regard to safeguarding adults and were aware of the local authority safeguarding procedures and policy on how to respond to suspected abuse. One staff member said, "I have received training in safeguarding and I would never hesitate in reporting any concerns to my manager." Another member of staff told us that they were aware of how to raise a safeguarding concern and knew that the safeguarding procedures and information file were kept in the staff office. However, this understanding related to harm caused through intent. We found evidence that there was a lack of understanding of institutional abuse or that the manner in which day to day personal care delivery could 'dehumanise' a person, for example carrying out personal care without speaking to or acknowledging the person. We were aware of occasions where this type of practice had happened and found the registered manager had failed to recognise this; address with specific members of staff or make appropriate safeguarding referrals to the local authority. This meant people living at the service were not safeguarded from all types of abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safeguarding service users from abuse and improper treatment

There were risk assessments in place for the environment and running of the home which included fire safety, slips and trips and moving and handling. Equipment within the service was regularly serviced and intermittent safety checks made according to the manufactures instructions. However, a suction machine located in one bedroom because the person was at risk of choking, was plugged in but the necessary tubing was not attached, meaning there was no suction quickly available. We were told there was no formal system for checking this equipment regularly. We spoke with a nurse who re attached the tubing correctly. We stressed the importance of checking this equipment prior to supporting this person with a meal. We were given reassurance from the registered manager this would take place.

Where people were assessed as at risk individual risk assessments had been completed. We found in some cases the detail about action to take was brief. Although action recorded would reduce or eliminate the risk there was little information pertaining to the individual's needs which would take into account people's wellbeing or promotion of their independence. For example, two risk assessments we looked had an assessment completed for pressure relief with a score indicating a risk management plan should be developed; this had been completed but lacked specific detail. The record advised to nurse the person on a profiling bed and monitor for changes in appearance of pressure areas but it did not include details such as frequency of re positioning, support needs, views, wishes, likes, dislikes and routines.

We saw in one person's care plan they required assistance to be repositioned in bed with the use of a slide sheet as they were unable to reposition themselves. We were told this person was suffering from a chest infection and we observed them to be laid flat, which could have compromised the person's medical condition. When we asked staff about this and suggested they needed repositioning, we were told this person was able to reposition themselves. This was contrary to the care plan document. This meant that the person was at greater risk of tissue damage as there was no care plan to direct and guide staff about the frequency and type of repositioning as staff were under the impression that this person repositioned themselves.

We saw for another person their moving and handling risk assessment stated they required two members of staff to assist with personal care and repositioning. We observed on CCTV footage that some staff had not followed this advice and had moved this person on their own which appeared to result in an amount of discomfort for the person and placed them at risk of harm. This poor practice was later confirmed from records of the provider's own investigations. This matter is subject to a safeguarding investigation.

We also have evidence of a confirmed choking incident caused by poor staff practice and feeding technique which led to a need for medical treatment from the GP.

Accidents and incidents were recorded and the registered manager told us they reviewed these and took appropriate action to reduce the risk of reoccurrence. However, the registered manager had not recorded any analysis or formal tracking to identify patterns or trends. This meant there was a lack of overview, reflection and learning to reduce risks to people.

The evidence found meant risks had not been assessed or where they were the assessments contained insufficient detail to protect people from harm.

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

All the people we spoke with said that they felt safe. One person said that there was a weekly fire drill and staff came along and closed their doors and then came back and opened them again when the drill was over. Four people said they were safer in Rambla Nursing Home than they were in their own homes, as they had fallen in their own homes and at Rambla staff would help them move around. One person said that they thought the building had been set up with safety in mind.

The service had in place emergency contingency plans in the event of power failure or adverse weather for example. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

We looked at the recruitment records for six members of staff and two volunteers. There was a recruitment process in place to help ensure that staff who worked at the home were of good character and were suitable to work with people who needed to be protected from harm or abuse. Staff confirmed that they did not take up employment until the appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service [DBS] certificates had been obtained. The staff records we looked at indicated the recruitment process was not followed consistently. For one member of staff we saw the application form had not been completed fully and there were no interview notes available to evidence that previous employment and employment gaps had been explored during interview. There were no copies of relevant documents such as nurse qualifications and proof of identity. The registered manager told us there was a system to check the current status of nurse's professional qualifications with the Nursing and Midwifery

Council (NMC) every month; however this was not evident on one staff member's records.

This meant that the registered provider did not follow safe practices to assure themselves that staff employed at the service had the appropriate skills and qualifications to carry out their role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Fit and Proper Persons employed.

People had access to bathrooms that had been adapted to meet their needs; people had specialist equipment such as wheelchairs, specialist beds or bathing aids to use whilst having a bath or shower. We noted that communal areas, stairs and hall ways were free from obstacles which may present an environmental risk.

We spoke with the manager about how they determined staffing levels and deployed staff. They told us staffing levels were determined according to the needs of people living at the service. We were told that 29 people were living at the service on the day of our visit and that 28 of these required nursing care. We found that for the early morning shift there would be two nurses and either five or six care staff on duty. For the afternoon shift there would one nurse and four care staff. Overnight there would be one nurse and two care staff. The registered manager explained there were more staff allocated to the early shift to attend to people getting up and attending to health care professional visitors and phone calls which tended to happen during this period. We reviewed the previous four weeks of staff rotas which reflected consistently the information the registered manager had provided. The registered manager told us there was a current vacancy for a deputy manager and although they did not use agency nurses there was difficulty in recruiting nurses in the local area. As such the registered manager, who was a nurse, worked on shift occasionally. This had recently included covering night shifts.

One person said that their call bell buzzers had been replaced with a new system and they were much better. Almost everyone told us that the only times when they waited for a response to buzzers was when the staff were very busy. Most people thought they did not wait too long for a response. One person said it appeared to be a longer wait time for a response at night-time but they said that it always seemed longer at night and thought it was their perception of time was more difficult at night.

During our previous inspection in April 2016 we identified that some of the systems in place with regard to the safe administration of people's medicines were not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we checked the systems in place for the safe storage, administration and recording of medicines. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Medication records were clear, complete and accurate and included allergies and a recent photograph.

We saw drugs liable to misuse, called controlled drugs were stored in a suitably locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Staff received regular medication training and this was up to date. This meant that the previous breach of regulation in relation to medicines was now met.

Requires Improvement

Is the service effective?

Our findings

The previous inspection in April 2016 reported a number of comments from a relative prior to the inspection which indicated they were not happy with the meals or the way a person was supported with food and fluids. They also raised a number of concerns about the management of clinical care, including pressure care and moving and handling. These concerns are currently being investigated through the local authority safeguarding team. We are awaiting the outcome of their investigations.

During this inspection we reviewed how the staff team managed people's nutritional health. We saw that the service used a recognised risk assessment tool; MUST (malnutrition universal screening tool). The tool is designed to take into account a person's weight against a set of variables with action to take against a cumulative score and percentage weight loss. Dependent on the score specific action is advised. For example; weighing weekly, commencing food and fluid charts, and referring to GP and or specialists such as Speech and Language therapists (SALT).

We reviewed four people's records and risk assessments where it had been identified that they had experienced weight loss or were at nutritional risk.

For one person we saw their care plan stated they required full assistance at meal times and that they should be weighed monthly to monitor weight loss. We saw recorded that they had a weight loss of 2.8kg which amounted to the score indicator of 5-10% and the GP had prescribed supplements. This amount of weight loss would indicate the person required weighing every week however no weights had been recorded since August 2016. When asked staff told us there was no need to commence food and fluid charts for this person. This meant this person's weight loss and food and fluid intake could not be confidently monitored placing them at further risk of weight loss.

We saw from monthly weight records that another person had lost 3.5kg. We reviewed their records and could not see a specific nutritional plan. There were no food and fluid charts in place for this person. We did locate information in their care records which determined they were in the palliative stage of life. However there was no care plan indicating this or that part of their condition may account for significant and rapid weight loss.

We spoke with staff about managing people's nutritional risk and what action they would take. Staff were unable to confidently tell us what factors they would consider when identifying weight loss. We asked the registered manager for the policy for managing nutritional risk. The policy we were provided with related to provision of nutritional food and providing people with adequate quantities of food and fluids. There was no procedure which directed staff to the action to take for risk of malnutrition. We found that staff had not followed the MUST guidance for at least two people.

We saw that sit on weighing scales had not been calibrated and although we were told a new sling weighing scale was available the weight records did not indicate which scales had been used therefore the accuracy of people's weight could not be determined.

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

Almost everyone we spoke with said they liked the food, one person said, "It could be more varied after all fish and chips every Friday 52 times a year, do we have to?" Another person said, "The food is lovely, very tasty." People mentioned to us that you could have an alternative at evening meal but the main lunchtime meal was a set meal with no daily choice.

Most people were frail and were either nursed in bed or reportedly preferred to stay in their rooms. Only four people came to the dining room for their lunch. People appeared to enjoy their meals and a member of staff was available in the dining room to assist. We saw they promoted independence and only got up to help when they could see help was needed. Although there was no set choice on offer we saw people had an alternative meal as their likes and preferences were well known by the staff and chef. One person wanted a different drink but was not permitted for health reasons and the member of staff took time to explain why she couldn't have that drink and offered an acceptable alternative.

We observed a member of staff assist someone with their meal in a particularly patient and sensitive manner. They followed this person's care plan to ensure they were positioned correctly and spent time assisting them at a pace which was comfortable for the person.

We spoke to the chef who told us all food was fresh and locally sourced. They baked every day to ensure fresh cakes and high calorie smoothies were available to supplement people's diet where they were at risk of weight loss. They told us they had a good relationship with people and they knew people's preferences. Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals. We heard staff encouraging people to drink sufficient fluids.

We discussed with the registered manager the training arrangements for staff. They told us newly appointed staff completed a comprehensive induction which included face to face and e learning. This included health and safety training such as moving and handling, first aid and safeguarding adults. Staff also completed a period of shadowing. Shadowing is where new care staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them. Nursing staff were required to complete regular updates for clinical practice such as use of a syringe driver and catheterisation. The registered manager provided a training matrix which recorded when staff had completed training and when they were due to complete updates. We saw some gaps in the record which the registered manager assured us related to staff who were not currently at work.

Staff told us they received supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. Staff also completed an annual appraisal. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. The records told us that although there was a regular pattern for supervision some of these had been missed recently. The registered manager told us this was because of additional demands on her to work particularly working on the rota as a nurse. However, they explained this did give them an opportunity to work alongside staff and provide 'on the job' coaching. Nursing staff received clinical supervision from the provider's clinical lead, who was also available as a source of advice to nursing staff.

We saw care practices by several staff members on CCTV footage which raised serious concerns over supervision of staff and their practice when working with people using the service. Also, the need for registered nurses to lead other staff designations by examples of best practice at all times.

As a result of evidence reviewed outside of the inspection visit we recommend the registered provider carries out a review of training and supervision to ensure staff have the skills and competencies to carry out their role.

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

The care records we looked at showed that, where appropriate, people had received a mental capacity assessment to determine whether they could consent to aspects of their care, such as the administration of medication. Where people were assessed as lacking capacity we saw that appropriate DoLS authorisations had been applied for and agreed by the relevant authority.

During the inspection we saw that staff consistently asked people for their consent, for example asking people if and when they wanted assistance with personal care.

There were records in place regarding visits and support that people received from external health care professionals. We saw that people had regular appointments with GPs, chiropodists, opticians and community nurses which demonstrated they were supported to access a range of health care professionals as required. A relative told us that the staff always kept them informed of any health care issues affecting their family member.

Requires Improvement

Is the service caring?

Our findings

Whilst the vast majority of people using the service expressed satisfaction we saw evidence, relating to at least one person who could not speak for themselves, of approaches by staff which were clearly uncaring and lacked respect and recognition of the individual. Inspectors identified significant variations in caring for people who used the service with strong and supported positive feedback from people who could speak for themselves. However, there was undisputable evidence of poor and unacceptable care delivery to at least one vulnerable, bedbound person who was unable to communicate with inspectors. These findings were supported by the police and other health and social care professionals who had also observed the evidence provided to them from camera footage.

The registered provider and his senior management team also agreed with the concerns that were identified.

People we spoke with said that carers were kind and treated them with respect and dignity. They told us that the staff were very caring and the care was very good. One person said, "Carers can't do enough for you, they are very supportive and very good with bereavement, I have lost two people close to me and they were excellent with their support."

Relatives that we spoke with were very positive about the care their family member received and one relative said, "All of the staff are so caring I would not hesitate to recommend here." Another relative told us that, "The atmosphere is really lovely and the home is always cheerful and very homely."

Most people said that staff knocked on their door and introduced themselves when they came into their bedroom, although one person, who was sight impaired said they sometimes did not do this and said, "I have to go by the sound of their voice."

On the day of the inspection we observed staff treating people with dignity and respect and being discreet in relation to personal care needs. We saw that if people were in their rooms, staff knocked on the door and waited to be invited in before entering the room. One person told us, "Even when the door is open they always knock on my door and wait to come in." We saw that staff closed people's doors before providing any personal care to them.

Another person told us, "This is a lovely place if you have to have care. Admittedly it's not my own home but that said it couldn't be any better, the staff are lovely people."

During our visit we saw a lot of positive interaction between staff and people who lived at the home. We saw that the staff showed patience and gave encouragement when supporting people.

Staff we spoke with were positive about working with people using the service. They were clear and enthusiastic about the value of the relationships they had established with people. One member of staff told us, "The best part of the job is the residents. If you can take away some of their suffering and see them smile

that's what we aim to do." Another member of staff told us, "Working here is great, and it's not really like being at work at all, I have been here 10 years." This showed that the staff cared about the people they supported.

Most people were nursed in bed or preferred to spend their time in their rooms but people were able to decide where and how they spent their time. People told us they were involved in decisions about their care and were able to choose what they wanted to do and when. Examples of this included getting up in the morning, what time they went to bed and how they spent their day. One person told us they felt staff did not have much time to chat but said, "I came here with misgivings but I have been pleasantly surprised."

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. Overall, people looked comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected.

During the day we saw visitors coming and going; they were offered a warm welcome by staff. We spoke to two visitors who said they were very happy with the care their relatives received.

Staff spoke with us about supporting people towards the end of their lives. They said they had received training from the provider but had additional training from the local hospice which was described as "excellent". One member of staff said this aspect of their role was "so important" and that they always ensured additional support for the person and their relatives.

The registered manager told us that people were provided with information as to how to access advocacy services when necessary. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

People were unclear about whether they had been involved in developing and signing their care plans. However, those we spoke with told us the staff had discussed the care and support they wanted and some people were aware this was recorded in their care records. One person told us, "If I wanted to change the ways things are done they are happy to accommodate this." Another person told us, "The staff here are always asking me what care I need and how they can best help me."

We looked at five people's care records and saw that they contained an assessment completed on admission which recorded people's needs and further care plans covering areas such as personal care, mobility, nutrition, daily and social preferences and health conditions. These contained sufficient information for staff to be able to provide support to meet individual needs. However, the care plans we looked at focussed on tasks to be completed and lacked person centred detail. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what is important to the person. For example, we did see in one person's plan detail about how to support them when they became distressed and upset. However, in another care plan, under the section 'personal care', the information recorded was, 'needs full assistance' without any further detail about how the person preferred this assistance. We saw in another person's care plan that they were in the palliative stage of their life. The registered manager and staff were able to talk to us in detail about this person's needs and preferences but the section in the care plan; 'end of life' had not been completed. This meant if information was not known by staff there was a risk care may not be provided appropriately.

Similarly care plans and daily records generally related to tasks to be completed, such as personal care given and meals eaten, with little evidence of the person's experience of the day or their wellbeing.

Care plans were reviewed regularly but in most instances this was recorded as 'no change to the person's needs,' which meant there was no recorded reflection about people's experiences or any goals for the future in improving people's quality of life.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Most people living at the service were able to voice how they preferred their care to be delivered and staff demonstrated they knew people well. The consistency and stability of the staff team helped ensure people received consistent support. This was commented on by a number of relatives in a quality survey. One relative commented, "Many staff have been there throughout, providing very important continuity." Another relative said, "Continuity is very important. Many staff working now were there when [relative] first moved in." And a visiting health professional commented, "Staff clearly know their residents and families well."

We spoke with the activities coordinator who arranged a variety of activities in consultation with people living at the home. They told us because many people remained in their rooms the focus of their time was supporting people on a one to one basis. They gave examples of making a scrap book of naval vessels for a

person who had been in the navy and had a real interest in this. She also gave examples of assisting some of the men to clean their electric razors and that this facilitated a more natural flow of conversation because they were involved in a practical activity. The service had a garden which most people told us they really appreciated and one person told us, "They have moved the bird table so as I can see the birds from my window."

We were invited into a number of bedrooms and found a lot of personalisation such as people's own choice of furniture, pictures, personal effects and photographs. One person said, "It has been great to be able to bring in some of my own furniture and make this room my own."

We saw that the provider had a complaints process. There was a complaints policy displayed in the entrance hall which told people how to make a complaint and the response they should expect. Some people were unclear about the complaints policy and who to make complaints to but most people and relatives we spoke with told us that any concerns they raised were promptly dealt with to their satisfaction by the registered manager and staff at the home. The registered manager told us they tried to 'sort things out at an early stage' in order to prevent concerns becoming formal complaints. They reported there had been no new formal complaints since the previous inspection.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the home who told us they had worked at the service for 21 years and had been registered manager for nine years. The registered manager explained that until August 2016 she had also taken on the role of general manager and nominated individual who represented the provider. This meant she had overall management supervision for three other services within the provider group and provider responsibility for governance of all four services. CQC would usually consider the two roles as incompatible as the role of nominated individual is to satisfy themselves of the management of individual services and line manage the registered manager.

Together with the registered manager working on shift as a nurse, the deputy manager relinquishing their role and the complex on going safeguarding matter referred to earlier in this report there had been added pressures placed on the management of the service. The registered manager acknowledged that the previous six months had been particularly challenging. We were told the role of general manager had been taken on by a registered manager of another service in the provider group since August 2016 and that the provider was currently recruiting into this post. This would then relieve both registered managers of additional roles and responsibilities. The registered manager also told us the post of deputy manager had been advertised.

We looked at the processes and systems which should be in place to ensure good governance. Good governance is the way the provider uses information to make the best decisions about providing a safe and high quality service for people. Evidence gathered throughout the inspection identified a clear lack of effective systems and processes to support any formal auditing and monitoring of the service. We found a lack of analysis or identification of patterns or trends with regard to people's weight loss, incidents such as falls and staff supervision.

Inspectors asked to look at records relating to the quality and monitoring of the service. The registered manager advised that some of the health and safety, environmental and quality audits would be out of date and this was confirmed when these were examined. However, we saw health and safety checks relating to fire safety and hot water temperatures were up to date. We saw evidence that equipment such as the passenger lift and hoisting equipment had been serviced in a timely manner. However there were no records relating to the calibration of the sit on weighing scales and no records relating to environmental checks. There were no monthly analysis of falls, specific incidents or consistent auditing of care plans for quality and completion.

Inspectors asked the registered manager to account for the shortfalls and they stated they relied on the knowledge they gained from 'working alongside staff as a registered nurse' and 'from being a hands on manager' to assess and evaluate the quality of the service they provided. They told us they updated the registered provider on the phone and when they visited the service. However, none of the discussions or actions were recorded in any format which could be referred to for progression and improvement. This meant there was no consistent, effective oversight or monitoring to ensure an improving service which was person centred, open and inclusive.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance,

During the previous inspection of 7 and 11 April 2016 a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This was due to medicine audits not being formally recorded; clinical monitoring charts not always completed accurately and risk assessments which were not always clearly linked with care plans to provide a consistent plan for staff to follow when offering care. In terms of the records and auditing with regard to medicines we found improvements had been made. This meant people received their medicines according to their prescription. We have commented earlier in this report about our findings with regard to recording and managing risk.

There was an open team work culture and staff told us they enjoyed their work and caring and supporting people who lived at the home. All staff we spoke with told us that they felt very well supported by the registered manager and that they were readily available to them for any advice or guidance. Staff told us that their suggestions for improvements were always considered and that they felt valued and listened to by the provider and registered manager. One member of staff told us, "She [the registered manager] always gives you time, if she can't see you straight away she makes time for you. She is very supportive of us all." Another member of staff said, "Morale has been poor recently but [name] has really supported us with team work to make this better, despite everything it's a great place to work."

Four people we spoke with thought the service was well managed and the manager was approachable and they saw her regularly. Our observations throughout the inspection were that the manager had positive relationships with people, they knew her and she knew them well. One relative wrote to us stating, "[The manager] is respected for her management skills but also she works on the floor with her staff so if there were any signs of standards slipping she would have addressed them directly."

People, relatives, visitors and staff were provided with a variety of ways on commenting about the quality of the care, including regular meetings and quality surveys. The provider had sent a survey out in August 2016 covering issues such as quality of care, attitude and approach of staff, decisions and choices, laundry, environment, activities and food. Of the 12 responses returned four people rated the service excellent, six good, one fair and one was not rated. Some of the comments recorded included, "There is a welcoming friendly environment and this is regularly commented on by family and friends who visit." Another comment included, "Thank you for giving us peace of mind knowing [relative] is very well cared for." Another comment read, "Nearly all staff have been with you for two plus years this can only help establish warmth and friendliness."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care provided related to people's individual lifestyles, choices and references.

The enforcement action we took:

We imposed an urgent condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe care and treatment of service users

The enforcement action we took:

We imposed an urgent condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure staff had a comprehensive understanding of what practice constitutes abuse.

The enforcement action we took:

We imposed an urgent condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems were in place to assess, monitor and audit the quality of the service provided.

The enforcement action we took:

We imposed an urgent condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure safe recruitment processes were followed.

The enforcement action we took:

We imposed an urgent condition on the provider's registration.