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Threeways Nursing Home

Inspection report

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Date of inspection visit:
13 December 2016
14 December 2016

Date of publication:
02 June 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

We carried out an inspection at Threeways Nursing Home on 11 and 13 August 2015 where we found the provider had not met the regulations in relation to safeguarding people from abuse and improper treatment and completing accurate and contemporaneous records in respect of people.

We undertook an unannounced inspection on 13 and 14 December 2016 to check that the provider had made improvements and to confirm that legal requirements had been met.

At this inspection we found the provider had taken action to meet the breach in Regulation 13 of the HSCA Regulations 2014, however they had not addressed the breach in Regulation 17 of these Regulations.

Threeways Nursing Home provides nursing and personal care for up to 45 people. At the time of our inspection 35 people were living at the home. People had various long term health care needs including diabetes, dementia type illnesses and other conditions which impacted on their mobility.
Threeways Nursing Home was on two floors with bedrooms and bathrooms on both floors accessed by a lift. The ground floor included a kitchen, laundry room, dining room, a main lounge and offices.

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

Although staff knew people well and had a good understanding of their individual needs and choices there were inconsistencies of detailed written information which could leave people at risk of receiving care and treatment that was inappropriate or inconsistent. This had not been identified through the quality assurance system.

Three people told us they were not supported to be involved in the assessment and planning of their care and treatment. Changes to people's needs were not always reflected in their care plans.

The audit systems had not ensured that actions identified at the last inspection had been addressed. The systems to assess the quality of the service provided were not always effective and had not identified the shortfalls we found.

Aspects of medicine management needed to be improved because guidelines in relation to the administration of some medicines were not clear.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place. The registered manager was familiar with the processes involved in the application for a DoLS, and had made the

necessary applications to the authorising authority. Although there was some improvement in relation to staff understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards people's rights to take risks had not been taken into account. These issues in relation to MCA and DoLS require improvement.

People told us they felt safe living at Threeways Nursing Home. There were sufficient levels of staff to protect people's health, safety and welfare. The provider had improved staffing levels based on the dependency of people's needs.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. Staff encouraged and supported people to eat and drink well. One person said, "The food is fresh and well presented."

Training schedules confirmed staff had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected. Staff had received regular supervisions with their manager to discuss additional training needs and development. Staff were encouraged to attend further training, with the majority having achieved the Care Certificate.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work and staff received a range of training that enabled them to support people living at Threeways Nursing Home.

There were a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk to people had not been appropriately assessed or regularly reviewed when people's needs changed.

Staffing levels were sufficient to keep people in the service safe however response time to call bells could put them at risk.

Some issues relating to medicines storage and record keeping were not safe. Medicines were administered and disposed of safely.

The premises and equipment at the service was well maintained.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

Checks had been completed on staff to ensure they were suitable and safe to work with people at risk.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported with their healthcare needs when appropriate.

Staff had a basic understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, they did not always have systems in place to document the reasons if someone lacked the capacity to understand a decision that needed to be made about their life.

Staff had received training and regular supervisions to carry out their role.

People were provided with food and drink which supported them to maintain a healthy diet. Staff protected people from poor nutrition and dehydration.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not respected by all staff.

Care plans did not always provide the level of detailed information to ensure that people's needs were met.

Staff had a good understanding of the history, likes, preferences and needs of the people who used the service, however this was not always recorded.

Staff had built a rapport with people and treated them with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always in place or updated to show current information on people's needs, preferences and risks to their care.

People's changing needs were not always recorded.

People decided how they spent their time, and a range of activities were provided depending on people's preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's systems for audit had not ensured people's records included relevant information about the care and treatment people needed or received.

Incidents and accidents were documented but not always analysed to identify trends to prevent reoccurrence.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

Threeways Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 December 2016. This was an unannounced inspection. The inspection team consisted of 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 service.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. As some people had difficulties in verbal communication we spent time observing to see the interactions between people and staff.

We looked at care documentation and reviewed records which related to the running of the service. We looked at five care plans and six staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' seven people living at Threeways Nursing Home. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked at all areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with 20 people who live at Threeways Nursing Home and twelve staff including the deputy manager. We also spoke with seven relatives who were visiting people during our inspection.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority and members of the public. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A

notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, this area was judged to be not consistently safe, and required improvement. Although people said they felt safe, we found a number of safety concerns during our inspection. People's safety was put at risk at times because risk assessments and risk management practices were not appropriate to their needs. For example four people had been assessed as being at risk of pressure damage. One of these people's conditions had changed significantly, but their risk assessment had not been reviewed. Another person did not have a care plan about how staff were to reduce their risk. When we spoke to staff they reported on different ways they reduced risk for the person. Another person sat out of bed for all of the inspection. A person's risk does not reduce when they sit out of bed, however they had no care plan about how their risk was to be reduced when sitting out of bed. When we spoke with staff, they gave us inconsistent replies about how they reduced the person's risk. The lack of, or inconsistent repositioning of this person was a major risk factor for them. Some senior staff demonstrated a lack of awareness of the basic principles of prevention of pressure damage. The National Institute for Health and Care Excellence (NICE) guidelines (2014) state that pressure wounds, once developed take and extended period to heal, can be very painful and present a risk of infection. At the last inspection, we recommended that the registered manager followed these guidelines. The registered manager had not ensured they had done this to prevent risk to people.

The provider and registered manager were not ensuring they prevented risk to people in other areas. A very frail person told us their condition had changed and they were now much less mobile than they had used to be. Their care plan for mobility outlined support a mobile person needed and had not been updated to reflect this change. It did document they had experienced falls but there was no care plan about actions staff were to take to support their mobility in the light of such falls. Agency workers were used to support people. As the person's care plan had not been updated, such staff would not have sufficient information to enable them to care for this person in a safe way.

At the last inspection we found medicines were not managed safely because guidelines in relation to the administration of some medicines were not clear. The provider and registered manager had made some improvements at this inspection but areas continued to need to be addressed. On the first day of our inspection we saw all of the morning medicines had been left on a chair in the office unsupervised. The office was door was open and any person would have been able to access these medicines. A nurse then picked them up to take them back to the trolley. We were told that they had been left because there was not enough space in the trolley.

One person had regular medicine via an injection. They had no records to show the injection sites were regularly rotated to prevent risk of tissue damage. Other people were prescribed regular medicines by skin patches, they also had no records to show sites of patches were regularly rotated. The service was using agency registered nurses at times, so would not have information on such matters available to them. Some people were prescribed skin creams. One of these people had no care plan about where their prescribed creams were to be applied or how often. Another person only had some of their skin creams documented. Neither of these people had records to show these skin creams were being applied to them as prescribed.

The above issues meant that people's safety and welfare had not been maintained. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

The provider and registered manager were ensuring they supported people appropriately in other areas. There were appropriate arrangements for the safe receipt, administration and disposal of medicines to ensure people received their medicines safely. People told us that they received their medicines on time and with supervision. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

People's medicine administration records (MAR) were accurate and clear. They showed each person had an individualised MAR which included a photograph of the person and any allergies. MAR charts are a document to record when people received their medicines. We observed when people were given their medicines and they were given safely. There was clear guidance in the MAR charts on 'as required' medicines (PRN). PRN medicines are only given when people require them for example for pain relief, they are not given routinely.

Although people said there were enough staff to provide care for them we found the provider and registered manager had not ensured their safety by ensuring they were responded to when they used their call bells. Care staff were allocated areas of responsibility for the day but it was sometimes unclear as to which staff should respond to call bells when they are rung. One member of staff told us, "Staff will go to any call bell. We may have to stop providing personal care to answer the call bell. The nurses will now answer call bells if required." Three people told us that they were unhappy with the response times when they used their call bell. We observed an occasion were the call bell monitor showed a period of in excess of 12 minutes before a person's call bell was responded to. The home services manager completed a monthly audit of the call bell system including the call bell response times in a seven day period. In October 2016 for the period 24 October to 30 October there were a total of 11.5% of calls which were responded to after 10 minutes. Although the home services manager told us, "We did have a problem with the call bell system but it is now working properly. I complete this audit and send it to the registered manager," they had not identified there continued to be issues relating to ensuring people's safety by a quick response to call bells. A dependency tool was reviewed monthly to determine staffing levels however the figures were incorrectly calculated so it was not clear how the service was meeting the changing dependency needs of people. People told us that staff understood their needs and were kind although we observed that they were not always given the time they needed to make sure the care people experienced was person centred and not task focused.

At the last inspection we found the provider had not met the regulation in relation to safeguarding people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

At this inspection we found improvements had been made and the provider was now meeting the requirements of Regulation 13 in relation to safeguarding people from abuse and improper treatment.

Staff had received safeguarding training and knew who to contact if they needed to report abuse. They gave us examples of potentially abusive care and were able to talk about the steps they would take to respond to it. One staff member told us, "It is about protecting our residents from any form of abuse. If I have any concerns I report them to a senior or the deputy manager." Another staff member said, "If I witnessed any abuse I would report it to social services." The training manager told us, "I make sure everyone understands the types of abuse and recognising abuse. We discuss a range of scenarios and complete practical exercises including reporting incidents."

Staff files included relevant checks on staff suitability including a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable adults. This ensured that only suitable people worked at Threeways Nursing Home.

All staff had received fire safety training and a fire safety policy and evacuation plan was in place. A fire risk assessment had been carried out in July 2015 and the recommendations from the assessment had been completed. Fire alarm tests were carried out weekly and staff knew where to assemble when the alarms sounded. A simulated evacuation was completed during the most recent fire training in July 2016 and there were regular checks completed on fire safety equipment. We reviewed people's personal evacuation plans (PEEPs) which identified the support people required during an evacuation.

People were cared for in an environment that was safe, clean and well maintained. People were able to move safely around the home with walking aids and the floors and corridors were clear of obstruction. Regular health and safety checks ensured people's safety was maintained. There were regular servicing contracts in place including checks on the lift, gas, moving and handling equipment and electrical appliances. Maintenance was carried out regularly with additional checks completed on the call system, pressure mats and water temperatures. A Legionella Risk assessment was completed in December 2016 and six monthly checks were completed on walking aids and wheelchairs.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found the service was not consistently effective. At this inspection the provider continued not to ensure they provided an effective service to people in all relevant areas.

Staff did not always demonstrate they had knowledge and understanding of how to support people to maintain people's good health. For example one person had a dressing on their leg and when we asked staff about the wound they did not know what it was for or when it had been dressed. There was also no record of the incident in the accident record or daily notes. Whilst in this case, the person's wound was healing, the risk to people was considerable due to the lack of staff awareness and documentation. A different person had a wound care record which stated it was to be redressed on 10 December 2016. We asked two registered nurses why the person's wound had not been redressed by the date stated on their record. They said they did not know if the person's wound had been redressed or not. Although the registered nurses could describe the person's condition, their wound assessment record did not reflect what they told us and so would not inform agency registered nurses about how the person's wound care and treatment needs were to be met. Wounds in older persons have the potential to change rapidly. The lack of effective record keeping and monitoring of people's wounds had the potential to put these people at risk to their health and wellbeing.

Other people told us that they were able to see a doctor, audiologist and optician when they wanted to. A person who was prescribed a urinary catheter had clear records which showed the service was complying with current guidelines on the care and treatment of people with catheters.

At the last inspection we found although senior staff had attended training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, support for people who did not have capacity was not always appropriate when planning care and support. At this inspection, we found although there was some improvement in relation to staff understanding and the management of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards we found examples of people's rights to take risks had not been taken into account. For example one person had been put on a pureed diet because staff had witnessed the person choking. The care plan did not reflect this and stated that 'all food should be cut up into small pieces'. A different person's condition had changed significantly since their last mental capacity assessment. However reviews of these people's mental capacity assessments or record of a best interests decision were not completed. These issues in relation to MCA and DoLS require improvement.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. Policies and procedures were available to staff on the MCA and DoLS. These provided staff with guidance regarding their roles and responsibilities under the legislation. Staff were trained in the principles of the MCA and DoLS and were able to describe the basic principles of the MCA. Staff sought consent from people before they helped them move around, before they helped with personal care and with eating their meals.

People told us the staff gave them the care they needed and were well trained. One person told us, "They know what they are doing and are very helpful." A relative said, "Staff are all very nice and I'm quite happy with things here."

Staff received training in safeguarding, moving and handling, fire safety, infection control and first aid. They completed an induction when they started working at Threeways Nursing Home and 'shadowed' experienced members of staff until they were competent to work unsupervised. The shadow shifts were reviewed by the training manager. Staff also received specific training to meet people's needs, for example catheter care. The training manager told us, "New staff won't work unsupervised unless I am confident that they have been properly trained. Staff have a three month probation period and we expect the Care Certificate to be completed within that time." The Care Certificate is a set of standards that social care and health workers demonstrate in their daily working life.

Staff received an annual appraisal and supervisions were completed quarterly to ensure they have the necessary knowledge to provide appropriate care and monitor the effectiveness of the training that they had completed. Staff told us that the supervisions were a useful method of ensuring that they can carry out their role effectively. One staff member said, "Getting feedback from your manager is a good way to check that we are doing things right."

People told us they liked the food at Threeways Nursing Home. One person said, "I eat everything and always get a choice." Another person said, "The food is very good and they cook what I want." The head cook told us, "We have a six weekly menu but various options and different meals get added to the menu as a result of the residents' meetings. There are two main choices for lunch but we offer alternatives and if we can do it, we do it." There were records of allergies and specific dietary needs such as pureed diets and controlled diabetes which were catered for. Documentation showed peoples' individual nutritional needs including preferences and portion sizes.

We observed the lunch time meal service on both days of our inspection. People either ate in their rooms or the dining room. On both days the majority of people ate in their rooms. The people who chose to eat in the dining room ate independently with some support. Staff ensured that people were positioned comfortably at their table and interacted in a respectful and supportive manner. People told us that they were not rushed to finish a meal and if they wanted to change their mind about the choice of food this was respected. One person politely refused food because it caused them pain to digest it. Three staff commented on this and the person explained why each time until another member of staff offered ice cream as an option which they happily ate.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found this area required improvement because the service was not consistently caring. The provider and registered manager continued to need to take action to address this area. A staff member told us, "Sometimes it can get very busy so we have to work as a team." People told us that there was a lack of consistency in staff supporting them. One person told us, "There are too many different faces." Another person said, "Staff are approachable but I'm not always sure I'm speaking to the right person." We observed some staff did not always knock on people's doors before entering their rooms.

Care was not centred on the individual and people were not well supported to express their views or make decisions about their care. Three people told us they were not involved in their care records and one relative told us their mother's care plan was only discussed when she started to live at Threeways Nursing Home. This meant that some of the people we spoke with had not been involved in developing their care plans. Other people gave more positive responses and all of the nine people who responded to the provider's survey stated their care plan was amended when changes occurred in their needs and wishes

Staff were not always caring. A person had been ringing their bell for over 12 minutes, they told a member of staff "I've been waiting for ages." The member of staff replied "No you haven't" to the person, and although it was said in a kindly tone, their comment was dismissive of what the person had experienced. Staff did not consistently address people appropriately. We heard a care worker calling down the corridor, asking a registered nurse to go and see a person, using their room number, not their name. This discrepancy in staff approach to people was not picked up on and corrected by senior staff.

People's dignity was not always respected and promoted. We found some clothes in the laundry which were not named or marked and also a pile of incontinence underwear which were readily available and had not been disposed of to prevent risk of their communal use. There was insufficient information in some people's care plans to ensure that they received the care and support they needed. This was particularly in relation to maintaining people's dignity by supportive management of their continence needs. A person had a care plan which stated they experienced occasional incontinence at night. Their daily record showed they were experiencing increasing needs in relation to continence through the day. A member of staff told us that a person was continent, although the daily records stated that the person 'had issues with continence.' These people's care plans had not been revised to reflect their current needs and ensure their dignity was maintained.

The above issues are areas which require improvement.

People were treated with kindness and compassion in their day-to-day care. Staff understood people's individual needs well and had built up a good rapport. People and their relatives said they were satisfied with the care and support they received. One person said, "I think it's marvellous here." A relative told us, "The staff are always very friendly and pleasant." Our observations confirmed that staff were caring in their attitude to the people they supported.

People felt that their privacy and dignity was respected. Staff were consistently discreet when offering to provide personal care to people and were able to give us examples of ways of protecting people's dignity, such as covering the person with a towel when undressing for a bath and closing doors and curtains to maintain privacy when giving personal care. Staff told us that people were given baths and showers when they wanted them. One person was asked whether they would mind if a male member of staff bathed her. She refused, so a different member of staff was found

We saw staff encouraging people with walking aids to move to different parts of the building safely. Staff were patient and took time to support them if necessary. People were appropriately dressed and well presented with comfortable clothing and footwear. A staff member told us, "I love working with the residents, I enjoy it."

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and were always made to feel welcome. A relative said, "We are always made welcome and staff are very pleasant"

Care records were stored securely in the office area. Confidential information including personnel files were kept secure in a separate office and there were policies and procedures to protect people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, we found the service required improvement because it was not consistently responsive to people. This was because their care plans were not personalised or based on enabling them to be independent. The provider and registered manager had not taken full action to address this area.

People and those important to them were not supported to be involved in the assessment and planning of their care and treatment needs. There was minimal evidence in people's care plans of their views on how they would like to receive their care and support. Staff recorded the personal care they provided in the daily records, however this information was not always transferred to the main care plan which meant specific guidance to ensure people's safety was not always in place. This also meant that staff did not have the necessary information to ensure that people received care and treatment that was centred on them as individuals.

Some of the people had needs relating to living with dementia. We met with a person who called out for assistance on a regular basis who also showed symptoms of hallucinations. We discussed this with staff, including a registered nurse, who confirmed these were behaviours which the person usually showed. Whilst the provider had taken some steps to assess the person's needs, the person's care plan did not outline how they were to be effectively supported with their behaviours which may challenge or distress themselves or others. They also had no records of the behaviours they showed, their frequency or possible triggers. We spoke with staff but they did not tell us about any strategies for supporting the person with their behaviours. We met with another person who also showed symptoms of dementia. This person had a recent daily record which described them as "Aggressive." Their bed rails assessment stated they could show behaviours which could put them at risk. The person's care plan only stated they experienced confusion but did not outline how staff were to appropriately support the person.

The provider and registered manager did not ensure people were responded to appropriately in other areas. Two of the people used specific aids to support their continence needs. They did not have any information in their care plans about how these aids were to applied and removed or any signs and symptoms to observe for to ensure their comfort and safety. When we asked staff about these appliances, we received differing responses about their use. Another person was documented as being a type two diabetic, they were very frail, had difficulties in communication and spend their time either in bed or their room. They had no care plan about management of their diabetes to ensure their comfort and diabetic needs were responded to.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that staff have the information required to meet people's individual needs.

People gave us mixed information about their involvement in the service. People said they could speak to the registered manager (matron) if they needed anything. Resident meetings had been held three times in 2016. People were invited to a monthly meeting known as 'matron's tea party' which was a social occasion

for people where a range of areas were discussed, including activities and forthcoming events. At least three people told us that they thought staff were too busy and there were too many different staff providing their care. One person told us, "The staff don't really have time to talk to me." Another person told us, "Sometimes my issues are not always addressed. They do ask, but as so often happens, that's the last I hear of it."

A residents' survey was completed in 2016 with 12 responses out of 35. People commented positively in relation to staff, care plans and day to day contact however some negative comments were made on issues relating to laundry, using the garden and activities and an action plan was put in place to address these.

There was a timetable of weekly activities on display in the hallway. These activities included pet pals, reminiscence, baking, crafts, a magic show, knit and natter, quizzes and scrabble. The activities organiser told us, "I only started six months ago but I love it here. The residents are incredible and so talented. I meet everyone every week and just over half of the residents take part in activities. In the early part of next year I will be identifying activities for residents who prefer to stay in their rooms." People told us that they had copies of the activities and were actively encouraged to attend. One person told us that the activities organiser was 'a scream' and that 'she never forgets if she's promised to do something'. Activities were individualised for people but the timetable provided additional activities for those people who wanted to participate. The notice board also showed forthcoming events and photographs of people at Threeways Nursing Home enjoying the activities they took part in.

During our inspection we saw people making mince pies, enjoying a carol concert performed by children from a local school and a singer who entertained people while they enjoyed tea and cakes. These activities were well attended and everyone seemed happy. The activities organiser told us, "The wish tree has been very popular. Each resident has the chance to write a wish and place it on the tree. I then make those wishes come true for example taking a resident out shopping or a trip to the seaside." We saw that work was in progress to record people's interests, what they enjoyed doing and what activities they had taken part in.

A complaint policy and procedure was available and a poster on how to make a complaint was on the wall in the main hallway. The complaints log showed there had been 1 complaint in the last 12 months which was acknowledged, investigated and dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found this area required improvement. The provider had not met the regulation in relation to maintaining complete and contemporaneous records in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014.

In May 2016 the Quality Monitoring team (QMT) from the local authority completed a Quality Assurance visit and reported their findings. The report suggested areas of improvement such as more consistent and robust quality assurance systems, to create more personalised care plans and to improve the quality of the medication audit. These areas of improvement had not been met by the provider and the deputy manager had not been made aware of the findings of the report.

At this inspection we found the provider continued to be in breach of this regulation. Quality assurance audits were completed which covered areas such as care plan reviews, catering and cleaning, health and safety, medication, equipment and maintenance. However, there was no evidence of what actions had been put in place to address any issues and outcomes were not always recorded. These systems had not identified people's risk assessments and care plans were not always accurate. For example one person had two care plans in relation to their diabetes, which included differing matters, neither of which outlined current good practice guidelines on supporting people who are living with diabetes. The provider had not identified this could be confusing to staff, particularly agency staff. Staff confirmed several of the people living at Threeways Nursing Home were at risk of dehydration, however the hydration assessments and care plans did not contain clear guidance to staff to ensure their individual risk was reduced. Two of the people who were assessed as being at high risk of pressure damage had care plans which stated how often they were to be supported in moving their position. We observed their positions were not moved within the timescales stated in their care plans; this was also reflected in their records of changes of position. The provider had not identified these and a range of other matters during their audits to ensure the health and well-being of people.

People were not protected against the risks of unsafe or inappropriate care and treatment because accurate and up to date records were not kept. Care plans including the daily records were not always clear and consistent to ensure that people received safe and person-centred care. For example, one person's care plan dated 28 January 2016 stated that they were mobile which did not reflect their current mobility status showing that they were 'unsteady and falls.' Although two falls were documented in the person's daily records, their care plan had not been updated since January 2016. Another person had a record which stated they were "in a funny mood." Such records do not accurately describe what a person's symptoms were, to ensure their needs could be appropriately supported. A person had a mattress set on the incorrect setting for their weight. We asked a registered nurse, who told us why this was necessary for the person. This had not been documented, to ensure all people caring for the person was aware of this specific need. The lack of written information left people at risk of receiving care and treatment that was inappropriate or inconsistent.

Incidents and accidents were reported and investigated, but not fully analysed to assess if there was any

action that could be taken to prevent the incident from happening again. This meant it was not clear whether the registered manager understood the importance of learning from incidents when they did occur to help people stay as safe as possible. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The home service manager completed a monthly review of call bell response times which were passed to the registered manager. We saw that a memo was sent to all staff in 2016 from the registered manager highlighting the issue but it was not clear that the issues were being addressed. In September 2016 10% of calls were answered within 6 to 10 minutes and 8% of calls were answered over 10 minutes. This did not improve in October 2016 when 11% were answered within 6 to 10 minutes and 10% of calls were answered over 10 minutes. One person told us, "The call bell? It's as slow as a snail to get help." A relative told us, "Staff do respond and say they'll pop back but they don't always do." The provider and registered manager had not taken action to ensure the safety and well-being of people when they used their call bells.

There were some unnamed items of people's personal clothing, including underwear, in the laundry. The provider reported they had systems for the naming of people's clothing. However they had not identified this as an area for attention, so they could ensure people had their own possessions returned to them and risk of communal use of clothing was reduced.

The provider had not identified other areas of concern through their quality auditing. Throughout the inspection, we observed a range of doors which had a notice on them stating they were to be kept locked. These included sluice rooms. One of the sluice rooms also had an additional stained paper note on the wall stating the room needed to be kept locked. None of these rooms were locked at any time throughout our inspection. The provider had not taken action to ensure people's risk from having access to such rooms was reduced. The surfaces of four people's bed rail covers were deteriorating, so could not be fully cleansed, to ensure appropriate hygiene. The provider had not identified such matters and ensured any such bed rail covers were replaced.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not maintain complete and contemporaneous records in respect of each service user.

We did however, receive some positive comments about the management of the home. People and their relatives told us that the home was well run. A relative said that the service, "gives me peace of mind and I know my mum is happy here." Another relative told us that the registered manager kept them fully informed of their relative's needs and any changes to their wellbeing.

People who use the service gave positive feedback about the registered manager and staff. Comments included, "I am happy here and staff keep an eye on me to make sure I am well" and "I am pleased with the care I receive." Staff said the registered manager was accessible, helpful and supportive. One member of staff told us, "The manager is very approachable and if I need anything they will support me."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Lack of consistent detail in care plans and lack of updating records meant people received inappropriate care

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Lack of consistent recording of medicine administration

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of analysis and no record of analysis in respect of call bells, medication or care plan reviews.

The enforcement action we took:

Warning notice