Walkden Manor Care Home Limited

Walkden Manor

Inspection report

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Walkden
Worsley
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires Improvement

Overall summary

Walkden Manor is located in the Worsley area of Salford, Greater Manchester. The home is located on a busy main road and in Worsley and has good access to a range of shops and local transport routes. Car parking is available at the rear of the building and in side streets close by. We last visited the home on the 23 May 2013 and found that the service provider was meeting the requirements of the regulations.

We inspected Walkden Manor on 12 and 26 of November 2014. These were both unannounced inspections which meant staff did not know we would be visiting.

Walkden Manor provided personal care and accommodation for a maximum of 29 people, some of whom had dementia. The home has three floors and at the time of our visits there were 25 people living at the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the management of medicines, infection control, staffing, respecting and involving people, care and welfare and record keeping.

These breaches related to regulations 9,12, 17 and 18 of the fundamental standards to with regards to person centred care, safe care and treatment, governance and staffing. You can see what action we told the provider to take in the detailed findings of the report.

Medication was not handled safely. We found staff had allowed a controlled drug to run out for one person who lived at the home before it was re-ordered. This meant this person did not receive their medication for three days. This was a breach of regulation 13 of the Health and Social Care Act 2008 with regards to management of medicines. This relates to regulation 12 of the fundamental standards with regards to safe care and treatment.

We found there were not enough staff at night to safely meet the needs of people who lived at the home. We arrived at the home at approximately 6.30am on both days of our inspections and found only two care assistants were on shift to provide care for 25 people with no senior member of care staff available. As a result, this meant there was nobody available to administer medication during the night if they needed it, such as pain relief. This was a breach of regulation 22 of the Health and Social Care Act 2008 with regards to staffing levels. This relates to regulation 18 of the fundamental standards with regards to staffing.

We saw certain areas of the home were unclean which posed the risk of infection to people. The dining room was dirty and was not cleaned in between breakfast and lunch. There was food on the floor, chairs and food stains on the wall. There was also food stuck to ornaments on the window ledge. We observed skirting boards around the home to have dust on them when we checked them. This was a breach of regulation 12 of the Health and Social Care Act 2008 with regards to cleanliness and infection control. This relates to regulation 12 of the fundamental standards with regards to safe care and treatment.

One person who lived at the home required re-positioning every two hours. We looked at the records completed by staff and found gaps in records between the 4 and 6 of November 2014. The manager told us that the turns had been completed, however could not locate the records. This meant we could not ensure this task had been carried out.

Another person who lived at the home was required to be re-positioned every two hours. We looked at the records completed by staff and found gaps in records between the 4th and 6th of November. The manager told us that the turns had been completed, however could not locate the records. This meant we could not ensure this task had been carried out. These were a breaches of regulation 20 of the Health and Social Care Act 2008 with regards to record keeping. These breaches relate to regulation 17 of the fundamental standards with regards to governance.

We were told by staff that at lunch time, four people needed assistance to eat their food. We observed staff sat in-between two people at the same time and provided assistance rather than providing individual support. This was not a dignified way for people to eat their food and although they did complete their meal, the food would have been cold. During breakfast, on the second day of our inspection we saw one person was not supported to eat their food despite it being recorded as a requirement in their care plan. These were breaches of regulation 9 of the Health and Social Care Act 2008 with regards to care and welfare of people who use the service. This relates to regulation 12 of the fundamental standards with regards to safe care and treatment.

We found peoples choices and personal preferences were not always adhered to. This was because people were not able to choose when they got up in the morning and were instead woken by staff. We spoke with staff during the second day of our inspection who informed us that in the past, there had been a culture at the home where it was expected that a certain number of people would be up from bed by the time the day staff arrived on shift. This was a breach of regulation 17 of the Health and Social Care Act 2008 with regards to respecting and involving people who used the service. This relates to regulation 9 of the fundamental standards with regards to person centred care.

Generally, people and their relatives told us they were treated with dignity and respect.

Summary of findings

There was a training matrix used to monitor the training requirements of staff which showed they had undertaken training in a variety of areas. Some topics were listed as 'booked' and needed updating such as safeguarding and infection control with a Deprivation of Liberty (DoLS) session for all staff confirmed for December 2014. Some people who lived at the home suffered from dementia, however the training matrix identified three members of staff had not completed dementia training at all, one person last completed the training in 2010 and one in 2011.Other staff had done this in 2013. We raised this with manager who told us these staff would be booked on to the course.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) with systems in place to protect people's rights under the Mental Capacity Act 2005. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms.

We saw evidence the home involved, and worked closely with other health professionals such as GPs, opticians, district nurses, physios and podiatrists. Staff supervision and appraisal was consistent. The manager told us they took place 'quarterly' and we saw records to confirm these had taken place.

We looked at the surveys which were sent to residents, professionals and relatives. No overall analysis of these had been completed and there was no evidence of how things raised had been responded to. This meant it was unclear how peoples views and opinions were used to improve the quality of services provided.

At the time of the inspection the registered manager was spending time at Walkden Manor as well as providing management cover at the sister home in the area. This meant the manager was not always available to provide guidance to staff when they needed it and monitor what was going on. A relative commented; "At the minute, the manager is here one day a week at the most".

There were a range of audits completed at the home, however they did not identify what action had been taken as a result of issues that were identified. In addition, there no trends analysis on the back of accidents and incidents to monitor any re-occurring themes.

We identified three instances where appropriate notifications had not been submitted to the CQC as required by the registered manager. This included a fall where somebody was hospitalised and two safeguarding incidents which occurred at the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. We found staff had allowed a controlled drug to run out for one person who lived at the home before it was re-ordered. This meant this person did not receive their medication for three days.

We found there were not enough staff at night to safely meet the needs of people who lived at the home. We arrived at the home at 6.30am on both days of the inspection and only two care assistants were on shift to provide care for 25 people and no senior carer. As a result, this meant there was nobody available to administer medication during the night if they needed it.

We saw certain areas of the home were unclean which posed the risk of infection to people who lived at the home.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective. Some people who lived at the home suffered from dementia, and we found the environment had not been adequately adapted to meet their needs.

Staff at the home had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) despite having not yet undertaken any training. MCA and DoLS are laws protecting people who are unable to make decisions for themselves. There were no DoLS in place at the home, however staff knew the correct procedures to follow to ensure people's rights were protected.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring. We found peoples choices and personal preferences were not always adhered to. This was because people were not able to chose when they got up in the morning and were instead woken by staff.

Some people who lived at the home did not receive adequate support to eat at both breakfast and lunch time, despite this being recorded in their care plan as a requirement.

The people we spoke with seemed happy living at the home. We saw staff offered them choices of baths and showers during the morning of our inspection.

Is the service responsive?

Inadequate

Not all aspects of the service were responsive. One person who lived at the home had been referred to a dietician and should have received additional fluids as part of their care. We spoke with this persons relative who said; "They

Summary of findings

do not give her enough fluids and I am at the home a lot. When they do, my mum often spills it and staff don't even notice". The fluid charts we looked at indicated that sufficient fluids had not been given and that accurate records had not been maintained.

One person who lived at the home required re-positioning every two hours. We looked at the records completed by staff and found gaps in records between the 4 and 6 of November 2014. The manager told us that the turns had been completed, however could not locate the records.

We looked at the surveys which were sent to residents, professionals and relatives. No overall analysis of these had been completed and there was no evidence of how things raised had been responded to. This meant the information gathered was of little value to staff and people who lived at the home.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led. The registered manager was spending time at Walkden Manor as well as well as providing management cover at the sister home close by. This meant the manager was not always available to provide guidance to staff when they needed it and monitor what was going on at the home. A relative commented; "At the minute, the manager is here one day a week at the most".

There were a range of audits completed at the home, however they did not identify what action had been taken as a result of issues that were highlighted. In addition, there was no trends analysis completed to monitor any re-occurring themes with regards to accidents and incidents.

We identified three instances where appropriate notifications had not been submitted to the CQC as required by the registered manager. This included a fall where somebody was hospitalised and two safeguarding incidents.

Walkden Manor

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 unannounced inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. An inspection manager also joined the team for the second day of the inspection.

We inspected the service on 12 and 26 of November 2014. At the time of the inspection there were 25 people living at the home. The manager was registered with the Care Quality Commission and was available to assist us throughout the inspection. Over the course of the inspection, we spoke with 11 people who lived at the home, four relatives and eight members of staff. We were able to look around the building and viewed records relating to the running of the home and the care of people who lived there.

Before the inspection we reviewed all the information we held about the home including the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also liaised with external professionals including the safeguarding, commissioning and infection control teams at Salford local authority.

We were able to speak with people in communal areas and their personal rooms. Throughout the day we observed care provided in certain areas of the home. We observed each of the three main meals of the day including breakfast, lunch and part of the evening meal.

We carried out a Short Observational Framework for Inspection (SOFI) over the lunch time period in the dining room of the home on the first day of our inspection. SOFI is a specific way of observing care to help us understand the experience of people using the service who could not express their views to us.

Inadequate

Is the service safe?

Our findings

The people we spoke with who lived at the home told us they felt safe. Comments included; "I feel safe living here. The staff treat me well" and "I trust the staff. I would speak with my daughter if I was afraid of anything or anyone".

We looked at how staff managed people's medication and found this was not always done safely. We found medication was stored in a locked trolley, which was kept in the basement of the home with only senior members off staff having access to the key. We looked at medication administration records (MAR) and found these had been accurately completed by staff when medication was given or refused.

There were also controlled drugs in use, which were kept in a controlled drugs cupboard. We saw a controlled drugs register was signed and countersigned confirming the drugs had been administered and accounted for. However, we found staff had allowed a controlled drug to run out for one person who lived at the home before it was re-ordered. This meant this person did not receive their medication for three days. We saw a fax, which had been sent to re-order the medication, but this had only been done once the medication had run out.

There was a medication fridge at the home, which was used to store certain medication at the correct temperature. However, we found temperature checks of the fridge were not recorded. This meant staff were unable to ascertain if medication was stored safely. In addition, on the second day of our inspection, we saw staff did not always watch people take their medication before walking away. We raised our concerns with the manager who told us she would address the issue with staff.

Some people who lived at the home required the use of PRN medication (this is medication given as and when required such as Paracetamol). We found there was clear guidance for staff to follow as to when this should be given. In addition, we found all senior staff had received training in the safe administration of medication.

We found that the registered person had not protected people against the risk of unsafe medication procedures.This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We found there were not enough staff at night to safely meet the needs of people who lived at the home. We arrived at the home at approximately 6.30am on both days of the inspection and only two care assistants were on shift to provide care for 25 people and no senior carer. As a result, this meant there was nobody available to administer medication during the night if they needed it. There were 12 people up when we arrived at the home, on the first day of the inspection; most of whom were in the lounge area, whilst one person was sat in the dining room alone. We observed the environment was loud and chaotic and although staff worked hard to assist people, they appeared rushed. There were also call bells ringing at regular intervals when other people required assistance who were still in their bedroom. This meant people who were in lounge area were left unattended when staff went to assist them.

On the second day of our inspection we again arrived at approximately 6.30am. We were told one person who lived at the home had recently returned from hospital the day before, after suffering a fall. The staff on shift told us this person had an 'unsettled night'. They thought this might be due to the person being in pain. However staff told us they had not been able to do anything about this due to their being no senior member of staff available to administer medication for pain relief. We raised this with the manager who informed us all night staff would receive medication training as a matter of urgency. The manager told us she would send us a dependency tool which identified how the current staffing levels had been put in place, however this was not sent to us following our inspection.

We found that the registered person had not protected people against the risk of unsafe staffing levels. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing.

The 'day shift' at the home commenced at 8am. Staff on shift included the registered manager, three senior carers, a care assistant, the cook and domestic staff. These members of staff were listed on the rota for the day of our

Inadequate

Is the service safe?

inspection. Generally, we observed this proved sufficient to look after people who lived at the home and provided care as necessary. During our inspection we saw people being taken to the toilet, assisted to walk or stand from their chair and given their medication which was inline with their care requirements.

We saw certain areas of the home were unclean which posed the risk of infection to people. The dining room was dirty and was not cleaned in between breakfast and lunch. There was food on the floor, chairs and food stains on the wall. There was also food stuck to ornaments on the window ledge. We also observed skirting boards around the home to have dust on them and a commode not emptied between 7am and 12pm. There had been a 'building audit' completed the day before our inspection, however none of the issues we identified had been noted. We raised these concerns with the manager and the local infection control prevention team who undertook a full audit of the home following our inspection.

We found that the registered person had not protected people against the risks associated with infection control. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

Staff were aware of risks to people and we saw plans in place to keep people safe. We looked at four people's care records during our inspection. Care plans contained various risk assessments such as falls, nutrition and pressure sores. Although risk assessments were reviewed at regular intervals, some of the documentation used needed updating. For instance, one persons risk assessment identified them as needing to be referred to the falls prevention team. However when we raised this with the manager, we were told this was no longer a risk for this person due to their decreased mobility. However the document was still being used by staff which meant the information given was not current and did not provide an accurate overview of the risk to this person.

We spoke with staff about people living at the home who presented with behaviour that challenged the service, asking how they would deal with this. One member of staff said; "Some of the people can get a bit agitated with the staff and other residents. Its important to defuse the situation and calm them down as much as possible. Usually it seems to work and its important to re-assure people". This demonstrated to us that staff had the skills and knowledge to deal with challenging behaviour in a way that kept people safe.

The staff we spoke with were clear about what could constitute abuse and how to report concerns. Staff were confident any allegations would be taken seriously and fully investigated to make sure people who lived at the home were protected. One member of staff told us; "I am aware of the different types of abuse that can occur such as financial, physical and emotional. I would speak with the manager and complete a SG1 (safeguarding) form if necessary".

Staff we spoke with were up to date with current good practice around safeguarding vulnerable adults and with reporting procedures. Staff told us they had received up to date training and found it beneficial in recognising and reporting abuse. The training matrix we were shown on the day of our inspection stated that safeguarding training was due for renewal and we saw evidence this had been booked for all staff for the coming months.

People were protected against the risks of abuse because the home had a robust recruitment procedure. During the inspection we looked at the personnel files for five members of staff including care staff, kitchen staff and domestic staff. The recruitment procedure minimised the risks of abuse to people who lived at the home by making sure all staff were thoroughly checked before commencing employment. We saw all potential employees completed an application form which gave details about the person and their previous employment. The home carried out interviews, sought references from previous employers and carried out Disclosure Barring Service (DBS) checks before people started work.

Requires Improvement

Is the service effective?

Our findings

Some people who lived at the home suffered from dementia, and we found the environment had not been adequately adapted to meet their needs. For example, there was a lack of signage and fixtures/fittings around the building which created a confusing environment for people who lived with dementia, as they manoeuvred around the home. There was also nothing to clearly distinguish how to correctly locate the toilet, as all doors and bedroom doors were a very similar in appearance. In addition, there was nothing displayed to let people know what time, day, month or season it was which could be confusing for people. We also observed a clock in the main lounge of the home to be stuck at 6.20 on both days of our inspection, which were two weeks apart.

On the first day of our inspection we observed the three main meals of the day (breakfast, lunch and part of the evening meal). This enabled us to see how people's nutrition and hydration requirements were met. Breakfast was served late on the first day of our inspection, at approximately 9.30am. This meant some people had been awake for approximately three hours without being offered any type of snack if they were hungry. Instead, we saw staff offering people biscuits, which was not a nutritious way for people to start their day. We raised this issue with the manager who acknowledged the lack of staff in the morning and was looking at bringing in extra staff for a few hours at busy times such as breakfast.

The lunch time meal consisted of either chicken curry or lamb chops with a side of mashed potato or vegetables. Rhubarb pudding and custard was available for those that wanted dessert. We observed adequate portions of food were served and people were offered second helpings if they wanted them. We saw a choice of drinks were offered at regular intervals throughout the day on request.

There was a training matrix used to monitor the training requirements of staff which showed they had undertaken training in a variety of areas. Some topics were listed as 'booked' and needed updating such as safeguarding and infection control with a DoLS session for all staff confirmed for December 2014. Some people who lived at the home suffered from dementia. However the training matrix identified three members of staff had not completed dementia training at all, one person last completed the training in 2010 and one in 2011.Other staff had done this in 2013. We raised this with the manager who told us these staff would be booked on to the course.

During our inspection we looked at the staff induction, which focussed on the common induction standards for care (CISC). The common induction standards enable staff to gain a thorough understanding of working in care. This covered the role of a support worker, personal development, communicating effectively, equality and inclusion, principles of care, health and safety safeguarding and person centred support. We spoke with six members of staff during the first day of our inspection who confirmed they undertook the company induction when they first started working at the home.

Staff supervision and appraisal were consistent. The manager told us they took place 'quarterly' and we saw records to confirm these had taken place. In addition staff had received an annual performance and development review. One member of staff said; "I've worked here a while and have regular supervision. The manager is quite good at making sure they take place".

Staff at the home had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) despite having not yet undertaken any training. MCA and DoLS are laws protecting people who are unable to make decisions for themselves. There were no DoLS currently in place at the home, however staff knew the correct procedures to follow to ensure people's rights were protected.

During our inspection we saw people were asked for their consent before staff provided care. For example, we saw staff asking people if it was ok for them to take their medication or if they wanted to go through to the dining room at lunch time. In addition, there were consent forms in people's files where people had given their consent to receive on-going care and any necessary treatment. Where people had been unable to sign for themselves, this was done by their relative. The manager told us some of these forms were in the process of being updated.

People had access to healthcare professionals to make sure they received effective treatment to meet their specific needs. Records showed people were seen by professionals

Requires Improvement

Is the service effective?

including GP's, community nurses, chiropodists and opticians. One person who lived at the home told us; "I see my doctor quite a bit and they are good at getting him in if I need it".

Requires Improvement

Is the service caring?

Our findings

We asked people who lived at the home if they felt the service was caring. Comments included; "The staff listen to me. They are kind to me and they allow me to be independent" and "The staff treat me with respect, they are not the least bit cheeky" and "The staff gee me up to get ready and help me to get washed and dressed. The care is very good".

We found peoples choices and personal preferences were not always adhered to. This was because some people were not able to choose when they got up in the morning and were instead woken by staff. We spoke with staff during the second day of our inspection who informed us that in the past, there had been a culture at the home where it was expected that people would be up from bed by the time the day staff arrived on shift. On the first day of our inspection, approximately 12 people were up and were either seated in the main lounge or dining area. On the second day of the inspection, four people were observed to be up from bed. One member of staff told us she had raised this issue with her senior carer during a recent supervision, where it had been acknowledged that this was not acceptable. As a result, they were now allowing people to stay in bed longer. They said that this was the first time they had started to allow people to stay in bed and felt it was working better. One member of staff said; "It has been much better in the last few days. We are starting to do things differently".

We spoke with two people during the inspection, on each day, who told us they would sooner have gone back to sleep rather than be woken by staff and taken to lounge area. One person said; "I was woken up this morning by the staff. I would have preferred to go back to sleep really". Another person told us; "I'm placed in my chair in the morning by staff. I would like to go back to sleep but they don't offer me the choice". We raised this issue with the manager who appeared to be aware that this had been taking place.

We found that the registered person had not protected people against the risks associated with not offering people choice. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred Care.

We found some people who lived at the home did not receive adequate support to eat at both breakfast and lunch time, despite this being recorded in their care plan as a requirement of their care needs. We were told by staff that at lunch times, four people needed assistance to eat their food. We observed staff sat in-between two people at the same time and provided assistance rather than providing individual support. This was not a dignified way for people to eat their food and although they did complete their meal, the food will have been cold.

We found that the registered person had not protected people against the risks associated with people not receiving care and support when they need it. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

Staff spoken with understood how to maintain people's privacy and dignity when providing care. One member of staff said to us; "When I am getting people up in the morning I like to allow them to wash themselves if possible. I would also cover them up with a towel and ask them what types of clothes they would like to wear". Whilst undertaking observations during the day we saw staff ensured people's clothing covered them properly when they transferred them from their chair into their wheelchair to ensure their dignity was maintained.

Generally, people and their relatives told us they were treated with dignity and respect, however one relative said to us; "Once, my sister had odd slippers on and the zip on her pants was broken so she was showing her underwear. That will have been embarrassing for her".

The staff spoken with were able to give examples about how to offer people choice and promote independence when providing care. One member of staff said to us; "One gentlemen who lives here uses a wheelchair but he can walk. I offer him the chance to use his zimmer frame otherwise his mobility would not improve. He walks a lot better now". Another person who lived at the home enjoyed rice crispies and toast for their breakfast and we saw this was provided for them during the inspection.

Inadequate

Is the service responsive?

Our findings

One person who lived at the home had been referred to a dietician and should have received additional fluids as part of their on-going care. We spoke with this persons relative who said; "They do not give her enough fluids and I am at the home a lot. When they do, my mum often spills it and staff don't even notice". The fluid charts we looked at indicated that sufficient fluids had not been given and that the home had not been responsive to this persons needs. The manager acknowledged this as being an issue but also felt it could have been down to poor recording rather than fluids not being given.

Another person who lived at the home required re-positioning every two hours. We looked at the records completed by staff and found gaps in records between 4 and 6 November 2014. The manager told us that the turns had been completed, however could not locate the records. This meant we could not ensure this task had been carried out and that potentially the home had not been responsive to this persons needs.

We found that the registered person had not protected people against the risks associated with poor record keeping. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Governance.

During breakfast, on the second day of our inspection we saw one person was not supported to eat their food despite it being recorded as a requirement in their care plan. We observed this person used their hands to hold the food at various intervals and the food was spilled on their clothing and was around their mouth. This meant the person's care was not delivered in a way that met their individual needs and maintained their dignity. We raised this with staff in the dining room who eventually provided assistance.

We found that the registered person had not protected people against the risks associated with not providing care and support to people when they need it. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

During our inspection we looked at the activities provided by home and to see how people were kept occupied and stimulated. There was no activity co-ordinator at the home and activities were undertaken by care staff. There was an activity schedule on the wall but this was not in use and appeared to be out of date. Apart from seeing some people playing a skittles activity in the afternoon, there was little stimulation for people during the day. One person who lived at the home said; "There isn't a lot going on for us here. We went to Blackpool the other week but that is about it". A visiting relative said to us; "There is not enough activities to stimulate my mum. She has gone a lot quieter since she came here. Usually there is nothing going on for people whenever I visit". We raised this with the manager about the lack of activities for people during the day.

We looked at the surveys which were sent to people who lived at the home, professionals and relatives. No overall analysis of these had been completed and there was no evidence of how issues raised had been responded to. For example, one of the surveys stated one person was not happy with the care at the home and we were unable to see how this had been investigated. This meant we could not evidence that the home responded appropriately based on feedback from people living at the home. The manager told us this was done verbally and would introduce a system to evidence how issues raised from the surveys were addressed.

An assessment of needs was completed prior to people living at Walkden Manor. This was to make sure it was the most appropriate place to meet people's care needs. Once people's needs had been assessed when they first arrived at the home, an individual care plan was then created. This enabled staff to gain oversight of the care people required and identified any individual preferences they may have.

We looked at four care plans during our inspection which covered areas such as mobility, bathing, nutrition, dressing, personal care and sleeping. We found these were reviewed at regular intervals if people's care needs changed or needed to be updated. We found care plans provided background information about the types of things people were involved with before they came to the home. This

Inadequate

Is the service responsive?

included where they were born, school, marriage, employment, social requirements and any likes and dislikes. This enabled staff to gain an insight about people's lives and learn about things of importance to them.

We saw evidence of where the home had been responsive to people's care needs. For example, we looked at one person's care plan whose appetite had decreased and the person was choosing not to eat or drink. There was a nutritional risk assessments in place and a referral to the the dietician had then been made. In response to this, staff had commenced a fortified diet, weighed the person weekly and maintained a food diary. As a result, this person had gained 2kg in November 2014.

We looked at the minutes from the last residents' meeting, which took place at the home in July 2014. This provided people with the opportunity to let staff know about anything they might like to change about the home or how things could be done differently. Items on the agenda had included activities, outings and purchases for the home. One person who lived at the home said; "I vaguely remember the last meeting. We can tell staff what we want". We saw the next residents and relatives meeting was scheduled for the end of November 2014.

The home had a complaints and comments process in place however the manager told us there had been no formal complaints about the home. One person who lived at the home told us; "I have confidence that if I made a complaint it would be responded too".

People who lived at the home had their religious and cultural needs adhered to. We were told a lay person from the local church visited the home regularly to deliver Holy Communion upon request. The manager told us people who lived at the home had also been able to visit the local church as part of remembrance Sunday.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We spoke with staff during our inspection and asked if they felt the home was well-led. Comments included; "I feel the home is well run. The manager is not here a lot at the moment though" and "The manager is good when it comes to training. I recently requested a further course to attend and I got put on it straight away".

The registered manager was spending time at Walkden Manor as well as providing management cover at the sister home close by. This meant the manager was not always available to provide guidance to staff when they needed it and monitor what was going on at the home. A relative commented; "At the minute, the manager is here two days a week at the most". We expressed our concern to the manager that this situation was not acceptable and that as the registered manager of this service, they needed to be at the home more often to support staff and ensure the smooth running of the home.

There were a range of audits completed at the home. These had not been effective as they had not identified the concerns that we found during the inspection. The audits did not identify what action had been taken as a result of issues that were identified. For instance, a recent audit of care provided in the home stated people looked unhappy and distressed yet we were unable to ascertain what action had been taken to address this. We raised these issues with the manager who told us she would introduce a system to show what action was taken if discrepancies were found during audits.

Although we found accidents and incidents were recorded, there was no trends analysis completed to monitor any re-occurring themes that may occur and potentially prevent them from happening in the future. This was something we raised with the manager who told us they would introduce this following our inspection.

This was a breach of regulation 10 of the Health and Social Care Act 2008 with regards to assessing and monitoring the quality of service provision.

We identified three instances where appropriate notifications had not been submitted to the Care Quality Commission (CQC) as required by the registered manager. This included a fall where somebody was hospitalised and two safeguarding incidents. The safeguarding incidents referred to a person who did not receive their controlled drug and an incident where a member of staff had shouted at a resident. The manager acknowledged these as an oversight and told us they would ensure appropriate notifications were submitted in the future. We contacted the provider following our inspection and are following this up outside of the report regarding this issue.

Staff told us there were opportunities to discuss issues and raise concerns whenever they needed to such as in supervision sessions. All staff were aware of the homes whistle blowing policy and the ability to take serious concerns to appropriate agencies outside the home. One member of staff said; "I have never needed to whistle blow but would not be afraid to report bad practice".

The staff we spoke with told us they attended handover meetings at the end of every shift. This kept them informed of any developments or changes within the service. Staff told us their views were considered and responded to. One member of staff told us; "I always get a decent handover from the night staff. Sometimes I can tell if things haven't been done though".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care had not been delivered in such a way as to meet the individual needs of, a service user.**

Regulated activity	Regulation
	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **We found the arrangements in place at the home did not protect people against the risks associated with cleanliness and infection control**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Suitable arrangements were not in place to ensure service users were treated with dignity, consideration and respect as staff were not respecting their choices about when they wished to get out of bed in the morning.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not ensure that an accurate record was maintained in relation to the care and treatment provided to each service user.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not ensure there were sufficient numbers of suitable qualified, skilled and experienced persons to undertake the regulated activity.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines An effective system was not in place to protect people from the risks associated with unsafe medication procedures.

The enforcement action we took:
We issued a warning notice with regards to this regulation.