

Park Homes (UK) Limited

Claremont Care Home

Inspection report




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Ratings

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

Summary of findings

Overall summary

The inspection took place on 10 May 2016 and was unannounced. We carried out a comprehensive inspection in April 2015 and rated the service as requires improvement. We found the provider had breached two regulations associated with the Health and Social Care Act 2008. We concluded that records relating to people's consent and Deprivation of Liberty Safeguards were not always accurate. We told the provider they needed to take action; we received an action plan. At this inspection we found the home was still breaching one of these regulations. However, some improvements had been noted.

Claremont Care Home is situated in Farsley, Leeds and is easily accessible by car and public transport. The home sits within extensive grounds consisting of lawned areas and a car park to the front. The home can accommodate up to 63 people. Some people were living with dementia.

At the time of our inspection the home did have a registered manager; however, they were no longer in day to day control. The regional manager was managing the home, who was in the process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some areas of the premises did not comply with current Health and Safety guidance and were therefore, a safety risk to people who used the service. However, a risk assessment had been completed. Staff received training but did not always receive appropriate ongoing or periodic supervision to make sure competence was maintained. The care plans we looked at did not contain appropriate mental capacity assessments. People's care plans were reviewed on a regular basis but the care plans were not always updated and it was difficult to locate information.

We found people were cared for, or supported by, sufficient numbers of suitably qualified and experienced staff. Appropriate recruitment procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work.

People told us they felt safe in the home and we saw there were systems and processes in place to protect people from the risk of harm. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe. People were protected against the risks associated with medicines because medicines were well managed but some slight amendments were required.

At the time of our inspection Deprivation of Liberty Safeguards were completed appropriately. There was opportunity for people to be involved in a range of activities within the home. People mealtimes experience was generally good. People received good support which ensured their health care needs were met. Most staff were aware and knew how to respect people's privacy and dignity.

People had opportunity to comment on the quality of service provided and influence service delivery. Effective systems were in place which ensured people received safe, quality care. Complaints were welcomed and were investigated and responded to appropriately.

We found breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this 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?

The service was not always safe.

We found some areas of the premises did not comply with current Health and Safety guidance. However, a risk assessment had been completed. Individual risks had been assessed and identified as part of the support and care planning process.

People told us they felt safe. The staff we spoke with knew what to do if abuse or harm happened or if they witnessed it. We found medicines were well managed with some slight amendments required.

Staff and people who used the service told us they did not think there were enough staff. The regional manager told us the staffing levels for each shift and the rotas confirmed this. The provider had effective recruitment procedures in place.

Requires Improvement ●

Is the service effective?

The service was not always effective in meeting people's needs.

Staff training provided equipped staff with the knowledge and skills to support people safely, however, staff did not have the opportunity to attend recognised supervision on regular basis.

Staff we spoke with could tell us how they supported people to make decisions. However, the care plans we looked at did not contain decision specific mental capacity assessments. Deprivation of Liberty Safeguards were made appropriately.

People's nutritional needs were met and people attended regular healthcare appointments.

Requires Improvement ●

Is the service caring?

The service was caring

People valued their relationships with the staff team and felt that they were well cared for.

Most staff understood how to treat people with dignity and

Good ●

respect and were confident people received good care.

Is the service responsive?

The service was not always responsive to people needs.

People's care plans were reviewed on a regular basis however, the care plans were not always updated and it was difficult to locate information.

There was opportunity for people to be involved in a range of activities within the home.

Complaints were responded to appropriately.

Requires Improvement ●

Is the service well-led?

The service was well-led.

The provider had systems in place to monitor the quality of the service.

People who used the service, relatives and staff members were asked to comment on the quality of care and support through surveys and meetings.

Good ●

Claremont Care 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 10 May 2016 and was unannounced. The inspection team consisted of three adult social care inspectors and a specialist advisor in Dementia.

At the time of this inspection there were 51 people living at Claremont Care Home. We spoke with four people who used the service, three relatives, one visitor, 10 staff, a consultant working with the home, the regional manager and a director for Park Homes. We spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at 11 people's care plans and five people's medication administration records.

Before the inspection, the provider had completed a 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 reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Is the service safe?

Our findings

We looked at the safety of the premises and found the home was clean, odour free and welcoming. People's rooms were varied in size but all were personalised and looked comfortable. We looked at some of the windows on the upper two floors of the home and found the windows did not have restrictors which complied with Health and Safety Executive guidance (HSE). We highlighted our concerns to the maintenance person who told us they would look at fixing appropriate restrictors to the windows immediately and was not aware of the HSE guidance. We spoke with the regional manager and director regarding the window restrictors who told us they had completed a risk assessment which showed the risk to people was low, therefore, the current window restrictors were sufficient. However, the risk assessment was not very detailed and did not include information relating to how wide the windows actually opened, the distances from the window to the floor and the type of surface anyone falling from such a window would land on. The providers risk assessment stated, 'Openable windows on floors other than the ground floor are fitted with suitable locks, catches and restraints. Residents have been risk assessed for mobility as not at risk as per HSE guidance'. The HSE guidance stated one of the categories of falls included 'falls arising out of confused mental state', which had not been taken into account by the provider. Even though there was a risk assessment in place further measures were not been taken to further reduce the risk.

We concluded the provider did not ensure the premises were safe for use for their intended purpose. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Care plans we looked at showed people had risks assessed appropriately and these were updated regularly and where necessary revised. We saw risk assessments had been carried out to cover activities and health and safety issues. These included pressure ulcers, bed rails and falls. These identified hazards people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions. However, we were told some staff were selective about the care tasks they were willing to carry out and where staff were late in getting people out of bed, they omitted to wash people to save time.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. We saw equipment had been regularly tested and all the certificates we saw were in date. For example, the homes lifting equipment certificate expired in July 2016. The gas and electrical certificates were both in date. Staff told us they recorded any faults in a book kept in reception and all repairs were carried out in a timely manner. We saw health and safety checks had been carried out in May 2016, which included bedrails, hoist slings, wheelchairs and hot water temperatures.

We saw the home's fire risk assessment and records, which showed fire safety equipment was tested and fire evacuation procedures were practiced. However, we noted the weekly fire alarm test was not carried out when the maintenance person was on leave. The regional manager told us they would address this. We saw

fire extinguishers were present and had been checked. There were clear directions for fire exits.

We asked staff about fire safety and were given mixed responses. One member of staff told us they had been instructed not to move people in the event of a fire. Another staff member said they were expected to carry out a 'horizontal evacuation' which was also stated in the fire notices on display in the home. We spoke with the person responsible for fire training and they were unable to clarify some of the actions staff were expected to take in the event of a fire.

We looked at how medicines were managed in the home. One person confirmed when they first moved to the home, staff told them about the different medicines they were taking and what each type was for. One relative told us a staff member had been in to see their family member to check whether they needed any pain relief.

Medicines needing refrigeration were appropriately stored in a clean fridge. Fridge and room temperature checks were carried out twice daily. However, we noted the procedure to cool the room when needed was to open a window. The registered manager told us they would review this. We saw medicines were kept safely and the arrangements in place for the storage of medicines were satisfactory. There were arrangements in place for obtaining medicines and adequate stocks of medicines were maintained to allow continuity of treatment.

Appropriate arrangements were in place in relation to the recording of medicines. For recording the administration of medicines, medicine administration records (MARs) were used. Stock was also checked against a 'tally' sheet. The MAR charts showed staff were signing for the medication they were giving. The MAR contained a photographic record for each person, details of the medicine and allergy information. However, we noted there were some issues with the accuracy of the 'tally' sheet. One staff member said, "Some of the staff don't do it." We spoke with the regional manager who said they would review this process.

The majority of medicines were provided in blister packs. The MAR contained 'special instructions' for each person, for example, 'give person half a tablet at a time on a spoon, remind him to swallow'. Personal preferences were also noted. For example, 'does not like diluted juice' or 'person will take with water, juice or tea.'

We saw one person had covert medication (hidden in food or drinks) protocols in place which, stated the person should be offered medicines and only hidden in suitable drinks should the person's behaviours challenge. We saw this was actively done by the staff member who was administering the medicines. The care plans we looked at also contained covert medication care plans where needed.

Some people were prescribed medicines to be taken only 'when required', for example, painkillers. One staff member told us they would either rely on the person to tell them they had pain or would use best judgement, for example, facial expressions, body positions and changes in mood. They said, "If the person can't communicate because of dementia they get pain relief anyway." We did not see any guidance with the MAR's or in people's care plans to help staff understand how people communicated pain.

The MAR and controlled drugs records were completed and no gaps were noted. We looked at medication stock and records relating to controlled drugs and found these were securely stored and accurate.

We were told by a staff member there had been medicines training this year which they had missed. They also said the manager accompanied them to observe a medication round.

We asked one person if there were enough staff. They told us, "Not really, but they can't afford any more." They told us if they used their buzzer to call for assistance, staff took no longer than two to three minutes. They said if staff were busy they went into peoples' rooms to explain any delays. One relative said, "They're just understaffed, I think." Another relative commented, "Like anywhere, they are understaffed."

We asked staff members about staffing levels. One staff member told us; "We struggle on some days with low numbers." Another staff member described staffing levels as, "Rubbish." A third staff member said, "Staffing levels were good at one point. We need some more staff." One staff member who commented on the presence of management in the home said, "There's no one here at the weekend. There are a lot of arguments, particularly on a weekend." One staff member said, "There are too many chiefs and not enough Indians." Another staff member told us, "I think managers should work on a weekend." Staff told us there were problems with staff sickness levels. They said the same staff members phoned in sick and when they returned to work no action was taken against them.

A staff member told us they were confident people were safe, but said they would not place a relative in this service. They commented, "I think there's too many kids employed." Another staff member told us younger staff used their phones in lounges and in people's rooms.

We spoke with the regional manager and one of the directors about staffing levels. They said they had the required staffing levels in place for the people they supported. The regional manager told us the normal staffing levels were two nurses and 11 care staff in the morning, two nurses and nine care staff on shift in the afternoon and two nurses and five care staff during the night.

The regional manager showed us the staff duty rotas and explained how staff were allocated on each shift. They said where there was a shortfall, for example, when staff were off sick or on leave, existing staff worked additional hours or bank staff were called upon. We looked at staff rotas for five weeks which showed on the majority of days the staffing levels were meeting the numbers stated by the regional manager..

Following our inspection the regional manager sent us a dependency tool they used to calculate the staffing level required and we saw this was reviewed on a weekly basis. However, we were not able to see how the calculation had been carried out to establish the number of staff required.

We saw the company had a staff recruitment policy which provided important information to managers. We found records were organised and up to date. We looked at four staff files. Each contained an application form detailing employment history, interview notes, offer of employment letter, references and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home.

The service had recently employed several new starters whose first language was not English. One staff member told us the day before our inspection a person asked them, 'Can you send them away because they don't understand me. How can they help me?' We spoke with the regional manager who said they would look at how new staff members were supported with their verbal and written English.

We spoke with some members of staff who told us they were working without a contract of employment. The director told us they were in the processing of re-issuing new contracts.

People who used the service said they felt safe and they liked living at the home. One person told us, "You're never left alone. They're checking on you all night." Another person said, I'm not badly done to, don't get me

wrong." Relatives of people who used the service said they felt their family member was cared for in a safe environment.

Staff we spoke with were able to identify different types of abuse and the signs which could indicate a person was being harmed. They told us they would report any safeguarding concerns to the nurse or the manager who were confident would respond appropriately.

The service had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. Staff were aware of the whistleblowing policy and how to report abuse outside the organisation. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. This meant staff were aware of how to report any unsafe practice.

Is the service effective?

Our findings

At the last inspection we rated this domain as requires improvement. Care plans did not contain appropriate mental capacity assessments and the Deprivation of Liberty Safeguards (DoLS) procedures were not followed. Following the last inspection the provider sent us a plan which identified how they were going to improve the service. At this inspection we saw the DoLS procedures were now being followed, however, care plans did not contain decision specific mental capacity assessment, although some improvement were seen as the provider was using a computer online system to produce mental assessments and best interest decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The regional manager had submitted DoLS applications to the local authority. They told us eight had been granted by the local authority and they were still waiting the outcome of others.

Staff we spoke with were able to tell us about the Mental Capacity Act (2005) and how this applied to their role. They described the choices gave to people around what time they wanted to get up, what they wanted to wear and eat. We saw staff training records showed staff had completed MCA and DoLS training in 2015 and 2016.

We saw staff gaining permission from people before they performed any personal care or intervention. We observed a number of occasions when staff approached people and spoke to ask for consent to providing support and care. One staff member asked a person near an open door in the lounge, "[Name of person] are you a bit nippy?." When they confirmed they were the staff member closed the door. One person who was being assisted in their wheelchair said to a member of staff, "I am a nuisance." The staff member responded appropriately by providing support and reassured them it was no trouble.

The care plans we looked at did not contain appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. One person's care plan did contain an assessment for 'inability to leave building due to a locked door' which was dated March 2015. The two stage test used was a computer generated document, which stated, 'the person has been assessed as lacking the mental capacity to make this decision about this particular issue at this time'. However, we saw a best interest decision for use of bedrails had been completed in March 2015, which stated, 'this person has been assessed as lacking capacity and the assessment has been documented', but there was no mental capacity assessment available from the online system on the day of our inspection. We also saw the person's capacity care plan date August 2014 stated, '[initials of person] has

been assessed to lack capacity.' We did not see any accompanying documentation to support this.

One person's care plan contained a 'Do No Resuscitate'. We noted a family member had been consulted. There was no MCA stating the person was not able to be involved or sign the document. We saw the person's capacity care plan dated July 2015 stated, 'need to make decisions in her best interests at all times'. We noted the capacity care plan review dated January 2016 stated, 'I lack capacity to make decisions'. However, no mental capacity assessment was available on the day of our inspection.

We did see one person's mental capacity assessment for day to day decisions dated February 2016 stated, 'the person does not have a mental impairment or disturbance and therefore, cannot lack the capacity to make a particular decision.' We saw this was signed by a staff member.

We noted one person had a DoLS in place but there was no mental capacity assessment in their care plan or on the computer system.

The regional manager told us they used a computer programme to carry out mental capacity assessments in all of the provider's services. They said the assessments were not kept electronically and for us to see the assessments they would have to complete a new assessment answering all the questions again. They said seven people had the mental capacity to make day to day decisions.

The above evidence demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We asked staff about their supervision. One staff member said, "I've not had any." Another staff member told us they had not had a supervision or appraisal since they started. Other staff members told us they had received three or four supervisions in the last 12 months. One staff member said, "The appraisals are very effective."

When we looked in staff files we were able to see evidence some members of staff had received supervision, however, these were topic specific. For example, infection control. We also noted observational supervision was carried out in the dining room. We spoke with the consultant who was supporting the home. They told us supervisions should be carried out six times per year and supervisions were carried out in 'response to something'. For example, when issues were identified as a result of an audit. They said, "No-one is responsible for undertaking supervision other than [name of two staff members]." We looked at the supervision matrix for 2015 and 2016 and saw not all staff had received supervision six times per year. For example, in 2015 one staff member had received two supervisions and in 2016 had not received any as yet. The providers supervision policy stated, 'to assist in the individual employee's personal development', 'to be a primary source of support for the employee', 'to provide regular and constructive feedback to individual employee on their performance' and 'every employee will be invited to a supervision session with their manager or supervisor at least six times each year'. We saw staff had received an annual appraisal.

The PIR asked, 'how many of your care staff have a named person that provides them with regular supervision?' The provider stated '63'.

We concluded the provider had not taken appropriate steps to ensure staff received appropriate ongoing or periodic supervision to make sure competence was maintained. This is a breach of Regulation 18(2) (Staffing); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about the training they received. One staff member told us, "Any time I've asked for any training, it's been provided." Another staff member said, "I haven't done any for a while. I never know where it is. What time it is." Staff told us training was mostly delivered through watching DVD's and completing questionnaires to check their knowledge. We were told staff were able to view a training manual in the nurses' station, although there was little pressure on staff to attend the sessions. One staff member commented, "Personally, I don't think it's pushed. They don't follow it through like they should."

We looked at staff training records, which showed staff had completed a range of training sessions. These included first aid, health and safety, infection control and end of life care. The regional manager said they had a mechanism for monitoring training and what training had been completed and what still needed to be completed by members of staff. They said the training was carried out by watching a DVD and then completing a knowledge test. The care co-ordinator reviewed the training needed by each staff member and the reviewed the knowledge tests when completed. We saw future training which had been booked, which included nutrition and food hygiene.

The PIR asked 'what improvements do you plan to introduce in the next 12 months that will make your service more effective, and how will these be introduced?' The provider stated, 'act upon analysis of staff appraisals and to encourage our nursing staff to become involved with training courses offered by Leeds City Council'.

We were told by the registered manager staff completed an induction programme which included orientation of the home, policies and procedure and training. We looked at staff files and were able to see information relating to the completion of induction. Staff told us they were satisfied with the induction they received. One staff member said, "I was shadowing for a while."

One person we asked about the quality of meals told us, "That's good. We get good meals." One staff member said, "It could be better." Staff told us the quality of meals depended on who was working in the kitchen. They said meals on offer ranged from corned beef hash to chicken burgers and chicken nuggets. One member of staff told us a person who required pureed foods and milkshakes did not always get this from staff.

We observed the lunchtime experience in the dining rooms and saw mainly positive interaction between people and staff. We saw tables were set with tablecloths and condiments were available. Staff asked people whether they wanted to have a drink of water or juice. We observed a staff member who provided assistance to one person which was unhurried. We saw another staff member sat beside the person and spoke discreetly using encouraging language about food and asked if they were enjoying the food. They were focused on the person. However, we saw one staff member rushing one person to eat their meal. They were not focused on the person and regularly broke off to chat with colleagues. They spoke with the person abruptly with frequent criticism. We fed this back to the regional manager who said they would address this with the staff member. Following our inspection we were told by the regional manager the providers disciplinary procedures had been implemented.

We spoke with the chef who was able to fully explain people likes, dislikes and was aware of people's dietary needs, for example, people that required a diabetic diet. The chef told us they had a four weekly menu with alternatives if people did not want what was on the menu. The food was freshly cooked and looked appetising. We saw snacks and drinks were available throughout the day with staff having access to the kitchen when the chef had finished work for the day.

We were told by staff the main meal was in the evening. They found people did not eat much at lunch, so the

midday meal was changed to a light lunch or sandwich.

One person told us, "The doctor comes every so often." On the day of our inspection we saw the chiropodist and a GP visited the home. We spoke with a health professional who was positive about the working relationship they had with staff in the home. We asked whether they felt staff responded appropriately to people's healthcare needs. They told us, "I'm called out on a proactive basis."

Staff told us all people living in the home were weighed on a weekly basis.

We saw evidence in the care plans that people received support and services from a range of external healthcare professionals. These included GP, dietician, practice nurse and there was evidence of people making visits to the optician or the optician visited the home if needed.

Is the service caring?

Our findings

People we spoke with told us they were very happy living at the home and staff were kind and caring. One person said, "She does everything for me. I wouldn't be without her. They're all good." Another person said, "She's a nice lass. She'll get me anything." One relative speaking about staff commented, "I think they're all good. [Name of staff member] is 11 out of 10. The others are 10 out of 10." Another relative said, "She has been really well looked after." Another relative said, "They do a good job."

People were very comfortable in their home and decided where to spend their time. The premises were fairly spacious and allowed people to spend time on their own if they wished.

We saw a member of staff explaining to one person that another member of staff had gone to find the correct sized sling in order to carry out a safe moving and handling transfer. As staff transferred people from wheelchairs to seats in the lounge we saw they explained exactly what was happening to people and encouraged them to take part where this was possible. One staff member was heard saying, "Are you ready [name of person]? We'll just move you into your chair."

We saw the regional manager talking with people throughout the day in communal areas. We heard them ask one person, "[Name of person] would you like to join in with the arts and crafts?" However, staff told us the regional manager did not normally walk around and talk with people. We also observed occasions when some staff were in lounge areas, but were not talking with people.

Relatives we spoke with confirmed they were able to visit their family members at all times of the day.

People we spoke with confirmed staff respected their privacy and dignity. One person commented, "They always knock on your door before coming in." Staff told us they respected peoples' privacy and dignity. One staff member told us they respected peoples' choice to have a male or female carer. Another staff member told us they knocked on doors and spoke to people before entering their rooms, closed doors and curtains and covered people when they provided personal care.

We asked one person whether they had any concerns about the laundry service. They told us, "They come back lovely."

We looked at one person's care plan which indicated they should have a shave every day. On the day of our inspection we saw this person was unshaven. We spoke with staff who acknowledged this had not been done and said it may have been because the person's electric shaver hadn't been charged.

We observed staff using the hoist on both units and found staff in general explained to people what was happening, however, we noted on two occasions there was limited conversation with the person using the hoist and some staff were chatting to each other and a visitor.

The PIR asked, 'what improvements do you plan to introduce in the next 12 months that will make your

service more caring, and how will these be introduced?' The provider stated, 'to develop the dignity champion scheme'.

Is the service responsive?

Our findings

We asked staff about care plans. One staff member told us, "They're there for us to look at if we want to. You don't get a lot of time to go and look at it. I wouldn't like to say if they're up to date." Another staff member said, "We want to read them, but we don't have the time to."

We found staff had mixed knowledge of peoples' care needs when we spoke to them. One staff member identified four people who were nutritionally at risk and required their meals to be fortified. When we spoke to another member of staff in the same area, they told us this only affected one person. We asked staff about peoples' life histories and found they were not always able to demonstrate this knowledge.

People had their needs assessed before they moved into the home. Information was gathered from a variety of sources, for example, any information the person could provide, their families and friends, and any health and social care professional involved in their life. This helped to ensure the assessments were detailed and covered all elements of the person's life and ensured the home was able to meet the needs of people they were planning to admit to the home. The information was then used to complete a more detailed care plan which should have provided staff with the information to deliver appropriate care. The care plans included communication, mobility, nutrition, personal hygiene, diabetes and skin integrity.

We saw people who used the service and/or their family member had not always been involved with reviews of the care plan and the person's needs. However, relatives we spoke with confirmed they had been invited to attend their family member's review meeting. They told us quarterly reviews took place and they received written notification to say when they were taking place. One relative we spoke with told us, "I am kept informed of anything that happens."

The PIR asked, 'what improvements do you plan to introduce in the next 12 months that will make your service more responsive, and how will these be introduced?' The provider stated, 'more communication with families'.

People's care plans did not always reflect the needs and support people required. The care plans contained detail to assist staff to understand how to provide care, however, changes were not reflected in the guidance part of the care plan and they were only noted in the review section. For example, one person's mobility care plan stated they needed a zimmer, however, the review notes stated they now needed hoisting and a wheelchair. We found the information in the care plans was difficult to find and they were not easy to follow. We noted some handwriting was difficult to read.

We saw reviews often contained one line stating care plan still effective. We noted from one person's care plan dated February 2014 a catheter had been removed in November 2015 but this had not been reflected in the care plan. Another person's care plan had not been updated to demonstrate a change in their mobility, which had declined.

We saw another persons' medication care plan review dated March 2015 for the use of covert medication

following a review by the GP had not been transferred into the summary of the care plan. We saw in one person's care plan a letter from the dietician dated March 2016, which stated, 'focus on nourishing drinks, fruit to be served with custard, ice cream or cream. Staff to offer nourishing snacks and drinks. Care home to document evidence of fortifying foods and offering drinks and snacks'. We noted this information had not been transferred to the person's care plan and the letter was not with nutrition care plan. We also noted in the 'healthcare professionals log dated March 2016 stated [name of person] to be encouraged to have snacks and fortified drinks. This information was not transferred to care plan; there was no guidance as to what to monitor and what would constitute a concern.

We found not all the care plans we looked at were updated on a regular basis, some sections were not completed appropriately or were inaccurate. This meant assessment of need or the designing of care was not carried out to ensure people's care and support needs were been met. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We saw a list of activities displayed in the entrance to the home. These included card making, chair exercise, baking, games, music with health, singing and pub lunches.

Staff told us a new activities co-ordinator had been appointed. On the morning of our inspection we saw the activities co-ordinator encouraging people to join a salt dough activity. One person told us, "She doesn't do anything we can't do." Another person said, "I did pastry making this morning. I enjoyed it." Relatives we spoke with were satisfied with the activities provided. One staff member who spoke about activities said, "They do their best." Another staff member commented, "The new lady is better. She gets a lot of people participating in it."

Staff told us the minibus owned by the home had not been used in several months as it required maintenance. Another home run by the same provider had a minibus, although staff told us they were not allowed to borrow it. A member of staff who was qualified to drive the minibus was no longer able to carry out this function for health reasons. Following our inspection we were informed by the managing director the minibus was available for all homes to use.

We asked people if they knew how to complain if they were unhappy with the service. One person told us, "I'd tell one of the attendants and they'd tell one of the bosses." Relatives we spoke with confirmed they knew how to complain.

The regional manager told us people were given support to make a comment or complaint where they needed assistance. They said people's complaints were fully investigated and resolved where possible to their satisfaction. We looked at the complaints records and found there was a clear procedure for staff to follow should a concern be raised and a copy of the complaints policy was displayed in the entrance to the home.

The PIR asked, 'what improvements do you plan to introduce in the next 12 months that will make your service more responsive, and how will these be introduced?' The provider stated, 'ensure responses to complaints are shared with staff members'.

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the Care Quality Commission, however, they were no longer in day to day control. The regional manager was managing the home who worked alongside staff providing support and guidance where needed. One the day of our inspection they engaged with people living at the home and were clearly known to them. Staff told us a director had been visiting the home regularly over the last few weeks.

One relative told us the service had changed for the better and described the carers as more intelligent.

We received mixed views about the management of the service. Comments included, "She's okay to your face", "I do like her and she stays calm and doesn't get aggressive. She'll say she'll do something and might forget. She's very approachable"; "We've just lost a good manager. I get on okay with [name of regional manager]"; "She's not a bad manager. [Name of regional manager] promises things. When you go to her nothing happens." One staff member told us, "I like working here. Another staff member said, "I don't feel like I am supported. I don't think you're looked after. You're just a number to them."

The regional manager told us they monitored the quality of the service by quality audits, resident and relatives' meetings and talking with people and relatives. We saw there were a number of audits, which included medication, infection control, catering and care plans. The audits were detailed and we saw evidence which showed any actions resulting from the audits were acted upon in a timely manner. We saw a checklist was completed three times during the day which included looking at bathrooms, bedrooms, housekeeping, training, medication and catering. This also included testing the response call bells of people who used the service. The regional manager also completed a daily report which included tissue viability, care plans and staffing. However, this was not always completed daily.

We saw the consultant had carried out checks of the home in February 2016, which included premises, staff and resident discussions, care plans, complaints, infection control, staff training and supervision and health and safety. We saw evidence an action plan had been created.

We saw staff meeting dates were displayed in the home for May and July 2016. We looked at the staff meeting minutes for April 2016 which showed discussions included laundry, kitchen, people's care and maintenance.

We saw a list of dates was displayed in the entrance to the home of when resident and relatives meetings were due to take place throughout the year. We looked at the meeting minutes for February 2016 which showed discussions included activities, care plans and refurbishment. We saw resident and relative meetings were scheduled for 2016, outlining meetings every two months. We saw manager's surgeries were also scheduled for 2016. We saw resident and relative quality assurance survey analysis for January to March 2016 displayed in the entrance to the home which showed results of good, very good and excellent to a range of questions asked. An action plan had been created showing areas the home wanted to make improvements on following the survey.

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence.

The PIR asked, 'what improvements do you plan to introduce in the next 12 months that will make your service more caring, and how will these be introduced?' The provider stated 'introduce a system where we can increase effective communication with the families and the people who use the service by telephone contact, regular one to one meetings. Continuation themed audits and prompt actions of analysis. To continue with manager's one to one surgery's for residents families. To improve the quality of activities to involve the local community more within the home'.

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 RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	The assessment of need or the designing of care was not carried to ensure people's care and support needs were been met.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	The care plans we looked at did not contain decision specific mental capacity assessments.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	We concluded the provider did not ensure the premises were safe for use for their intended purpose.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	We concluded the provider had not taken appropriate steps to ensure staff received appropriate on-going or periodic supervision to make sure competence was maintained.
Treatment of disease, disorder or injury	

