Summerfield Private Residential Home Limited

Summerfield Private Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and was carried out over two days on 18 and 24 August 2015. There were 30 people living at the home at the time of the inspection.

Summerfield provides care and support for up to thirty one people. The people using the service are predominantly older people and people living with dementia. The home is situated in Silsden near Keighley and is within easy reach of the town and local areas of interest.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 inspected the service in May 2014 and found the provider did not have suitable arrangements in place to make sure people's medicines were managed safety. The provider sent us an action plan and in December 2014 we carried out another inspection to check if improvements had been made. We found that although some improvements had been made further improvements were needed to protect people from the risks associated with the unsafe management of medicines. We gave the provider another opportunity to resolve this. During this inspection we followed this up to check if the required improvements had been made. We found they had not and people were not protected because the provider did not have proper systems in place to make sure medicines were managed safely.

People told us they felt safe. However, we found people were not always protected from abuse or the risk of abuse because the correct safeguarding procedures were not always followed. The service was not working in accordance with the requirements of the Mental Capacity Act and this meant people were at risk of being deprived of their liberty without the proper authorisation.

The provider told us they had enough staff to meet people's needs and when necessary they adjusted the staffing levels to take account of changes in people's needs. However, we observed there were times when staff were not available to attend to people's needs in a timely way.

We found people were not always receiving the right support to meet their nutritional needs. People were not always being supported to have access to the full range of NHS services, such as the services of dieticians or speech and language therapists when they had difficulties eating and drinking.

We observed a lot of positive interactions between staff and people living at the home and people told us the staff were kind and caring. However, we found the daily routines in the home were organised in way which was not conducive to promoting a person centred approach to care. For example, people who needed help to eat and drink were having their breakfast from 5.30am onwards with no evidence to show this was to meet their individual preferences.

We found people's needs were not always assessed and care plans were not always in place to guide staff on how to deliver care and support. This risked people not receiving care and support which was appropriate and met their needs. We found appropriate action was not always taken to manage risks to people's safety such as falls.

We found shortfalls in the way records were maintained about people's care and treatment and this created a risk that people would not receive appropriate care which met their needs.

The provider had processes in place to monitor and assess the quality of the services provided. However, we found they were not robust enough because they had not identified the shortfalls we found during the inspection.

We found the home was well maintained, clean and free of unpleasant odours.

There was a complaints procedure in place and people were given information about how to make a complaint.

We found the provider was in breach of a number of regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under

Summary of findings

review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 consistently safe.

People did not always receive their medicines in the way they were prescribed.

People were not consistently protected from abuse or the risk of abuse because the correct safeguarding procedures were not always followed.

Checks were carried out on new staff to check they were suitable to work in a care setting but this was not always recorded properly.

The home was well maintained, clean and free of unpleasant odours.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive the right support to meet their nutritional needs and health care needs.

People's rights were not always protected and promoted and they were at risk of being deprived of their liberty without the proper authority because the service was not working in accordance with the requirements of the Mental Capacity Act.

Is the service caring?

Requires improvement

The service was not consistently caring.

People who used the service and their relatives told us the staff were kind, caring and compassionate. This was supported by our observations during the inspection when we saw a lot of positive interactions between staff and people living at the home.

Some aspects of the way the delivery of care was organised did not promote a person centred approach to care.

Is the service responsive?

Inadequate

The service was not always responsive.

People were at risk of not always receiving care which was appropriate and met their needs.

There was a complaints procedure in place and people who used the service were given information about how to make a complaint.

Is the service well-led?

Inadequate

The service was not consistently well led.

The processes the provider had in place to monitor and assess the quality of the services provided were not robust enough.

Summary of findings

There were shortfalls in the records which potentially put people at risk of receiving care which was not appropriate and met their needs.

Summerfield Private Residential 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 18 and 24 August 2015 and was unannounced.

The inspection was carried out by two inspectors. During the inspection we used a number of different methods to help us understand the experiences of people who used the service. We observed how people were cared for in the communal areas and used the SOFI (Short Observational Framework for Inspectors) tool to help us gain an understanding of the experiences of people who had complex needs. We spoke with people who used the service and two people's relatives. We spoke with care staff, the cook, the deputy manager and the registered manager. We looked at nine people's care records, medicine administration records and records relating to the management of the home such as staff files, training records and maintenance records.

On this occasion we did not ask the provider to complete a PIR (Provider Information Return). 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 reviewed all information we held about the provider.

Inadequate

Is the service safe?

Our findings

At the previous inspection in December 2014 we found a breach of regulation with regard to the safe management of medicines. At this inspection we found significant concerns remained.

We found there were no systems in place to check medicines people brought in with them on admission were current and up to date. For example, we looked at the medicine administration record (MAR) for one person who had brought in their own medicines from home. The MAR had been handwritten but there were no signatures to show which staff had checked the medicines in. No stock levels were recorded on the MAR. When we asked the senior care staff member if the medicines the person had brought in had been checked with the person's GP to make sure they were correct and currently prescribed, the staff member told us this was not a process they followed.

We found discrepancies in another person's medicines as the administration instructions which had been handwritten on the MAR by staff did not correspond with the prescription labels on the medicines. For example, the prescription label on an antibiotic stated it was to be given four times a day, yet the MAR stated one dose to be given at night. The senior staff member told us they thought the dosage had been changed and increased by the GP but could not tell us when this had occurred or find any records to evidence this change.

We found gaps in the MAR where staff had not signed to show medicines had been administered. This meant we could not be assured people had received their medicines as prescribed. For example, one person was prescribed four medicines to be taken in the morning, none of which were signed as given on the MAR. We were able to establish that one of the medicines had been given as it was not in the dosette box. However, the other two medicines were packaged separately and could not be accounted for as stock levels were not recorded on the MAR. We also found this person was prescribed an antibiotic to be given three times a day over a nine day period. The MAR had been signed to show 30 tablets had been given over a ten day period, yet there were still two tablets left in the box. There were no stock levels recorded and the senior staff member could not account for this discrepancy. For another person there were three medicines which had not been signed for as given the previous evening.

We found some people were not receiving their medicines as prescribed. For example, we saw one person was prescribed an anti-inflammatory gel to be applied three to four times daily yet the MAR showed this had been signed as given on only one occasion in the previous eight days. Another person prescribed a similar pain-relieving gel three times a day had no signatures on the MAR to show this had been given over the previous five days. The senior staff member told us they thought these gels were to be given 'as required'. Yet there was no guidance with the MARs to show how often or when these gels should be used and staff were not recording if people had been asked if they required the gel or if they refused it. Another person was prescribed an antispasmodic tablet four times a day. This was not recorded correctly on the MAR and had not been given.

We found medicines requiring cold storage were kept in a medicine fridge and the temperature was monitored daily. However, the room where the fridge was kept was not locked and neither was the fridge which meant the medicines were not stored securely and could be accessed by anyone.

On the second day of the inspection the manager told us they had taken action to address the shortfalls we identified in relation to two people's medicines. We saw competency assessments with regards to medicines had been carried out on all staff this year.

We found medicine audits had been completed by the registered manager, the last one in May 2015 however the issues we identified during the inspection had not been picked up in the audit.

We observed when staff were giving medicines to people they were patient and kind and explained what the medicine was for. We saw staff stayed with people while they took their medicines, giving them assistance with drinks where needed.

This was a breach of Regulation 12(1)(2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The records showed staff received training on safeguarding during their induction and thereafter had updates some in house and some with an external training provider. The staff we spoke with had a good understanding of what constituted abuse and knew how to report concerns. However, when we looked at people's care records we

found safeguarding incidents were not always reported in accordance with the safeguarding procedures. This risked people not being consistently protected from abuse. For example, in one person's record we saw they sometimes behaved in a manner which put other people at risk. On the 10 August 2015 the daily record stated the person was "slapping two of the residents at the dining table". On 04 August 2015 the daily record stated, "has been quiet violent towards a few residents and staff." Similar entries were recorded on 03 and 29 June 2015 and on 25 June 2015 there was an entry which stated the person had been found in another person's room "after forcing the resident" out of their chair and sitting in it themselves. None of these incidents had been reported to safeguarding until after they were brought to the attention of the registered manager during the inspection.

In another person's records we found similar concerns. For example, we saw another entry about an incident which had taken place on 15 February 2015. The records showed the person had been "very loud and aggressive" and had hit another person who used the service. This had not been reported to safeguarding until 14 July 2015 and the referral had been made on the advice of a mental health community worker who had assessed the person's care needs on 13 July 2015. Despite this we found further incidents after 13 July 2015 had not been reported. For example, on 22 July 2015 the records showed the person had "walked past a resident in the dining room hit them in the face"; this had not been reported to safeguarding.

We asked the registered manager about these incidents and they told us they had not considered the incidents needed to be reported to safeguarding.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the usual staffing levels during the day were five care assistants, one of whom was a senior care assistant, from 8am until 2pm and four care assistants, including one senior from 2pm until 8pm. In addition, the deputy manager worked six days a week. The registered manager generally worked Monday to Friday and they were also supernumerary. Overnight there were three care workers, one of whom was a senior. There was an activities organiser who worked four days a week, one morning and three afternoons. Separate staff were employed for catering and there were housekeeping staff who worked five days a week, Monday to Friday. The registered manager confirmed there were no housekeeping staff at the weekend and the home did not employ separate staff for the laundry, this was done by the care assistants. The registered manager told us they operated a four week rota and employed enough staff to deliver the service.

The registered manager told us they kept staffing levels under review and changed them as necessary to take account of people's changing needs. The registered manager told us staff were allocated duties daily and this was based on how much support people who used the service needed, for example whether they needed one or two staff to assist them with personal care.

The registered manager explained the recruitment procedures. They told us all prospective employees completed an application form and had an interview. Following that checks were carried out to make sure the person was suitable to work in the care sector, this included a DBS (Disclosure and Barring Service) check to make sure they did not have a criminal conviction which would make them unsuitable to work in a care setting. At that point applicants were asked to work a two day trail period before a formal offer of employment was made.

We looked at the recruitment files of three staff. For the most part the records confirmed the information provided by the registered manager. In one of the staff files there were no written references, the registered manager told us they had contacted the person's previous employer on several occasions but had not received a reply. They said they had obtained verbal references for the person but this was not recorded

The registered manager confirmed they had a disciplinary procedure in place and said there were no disciplinary processes going on at the time of the inspection.

We looked around the home at a selection of people's bedrooms and the communal rooms. The home was well maintained and clean. The provider had arrangements in place to deal with day to day maintenance and there were service contracts in place for the ongoing maintenance and servicing of equipment such as lifts, hoists and fire safety equipment. The registered manager explained they carried out health and safety audits of the environment at three monthly intervals and we saw the records of audits carried

Inadequate

Is the service safe?

out in March and June 2015. The registered manager told us they walked around the home every day to check if there were any outstanding maintenance issues and to check the home was clean.

We looked at a selection of maintenance records included the gas safety certificate and electrical wiring certificate and they were up to date.

A number of people who used the service were people living with dementia. The registered manager confirmed they did not have a risk assessment in place for the internal stairs, however, they said they would deal with this immediately.

The windows in all the bedrooms on the first floor were fitted with window restrictors to reduce the risk of falls from a window. There was one small window in the bathroom on the first floor which did not have a restrictor fitted. The registered manager said they would deal with this immediately.

Following the inspection we received confirmation from the provider that the risk assessment for the stairs had been done and a window restrictor had been fitted to the bathroom window.

The registered manager told us they had an emergency plan policy and there was information around the home to tell staff who to contact in the event of an out of hours emergency. The registered manager confirmed they did not have a written plan in place setting out what actions staff should take in the event of major incident which required the service to be evacuated and had not identified a place of safety. They said they would address this.

The most recent external infection control audit was done in June 2014 and the home achieved a compliance rate of 98.8%. The home had a food safety score of 5 which equates to “very good” and is the highest score on a scale of 1 to 5.

Inadequate

Is the service effective?

Our findings

We looked at the care records of eight people who were nutritionally at risk and/or had a recent history of weight loss. In one person's records we saw they had lost 13.6kg in weight between November 2014 when their weight was 66.4kgs and August 2015 when their weight was 52.8kgs. The weight records showed the person had lost weight every month between November 2014 and August 2015. The last review of the nutritional assessment in May 2015 stated the person was prescribed supplements but was not taking them. The review stated the person's dietary intake was being monitored and they needed full assistance to eat a blended diet. The nutritional risk assessment identified the person as being at medium risk of malnutrition and showed their BMI (Body Mass Index) as 20. It was not evident how the BMI had been calculated as there was no record of the person's height. The person had a nutritional care plan which just stated "to monitor food intake". We observed the person at lunch time and saw they were given a full meal of meat and potato pie and peas, which was not blended. We asked the senior care worker about this and they said the person was no longer on a blended diet; it had been changed in the last week. We asked why they had been on a blended diet and the senior care worker said it was because they had struggled to chew and swallow. We asked who had made the decision to stop the blended diet and the senior care worker said the staff had decided they "would give it a try". We asked if a dietician had been consulted or involved and the senior care worker said they had not. We looked at the person's food and fluid charts. They were incomplete and it was not possible to see if the person was having an adequate diet. For example, on the chart dated 13 August 2015 the last entry was recorded at 11am and stated "sausage, mash, veg. – refused most of it. Jam roly poly & custard – refused. 100mls Complan". The chart dated 12 August 2015 had one entry which stated "Chicken, mash, veg – refused. Sponge – refused." The chart dated 09 August 2015 had only one entry recorded at 7:20am which stated "half porridge, cornflakes & 200mls tea." The chart dated 06 August 2015 had one entry dated 11am which stated the person had refused to eat and drink. The chart dated 03 August 2015 had only one entry at 11am which stated "3 spoons blended chicken and ham pie, mash and veg, 5 spoons trifle, 150mls Complan." There were no charts completed for 30 and 31 July or 01, 02, 04, 05, 07, 08, 10 and 11 August 2015.

In another person's records we saw they had lost 14.3kg between August 2014 when their weight was 66.3kg and August 2015 when their weight was 52kg. The weight records showed they had been weighed eight times, there were no weight records for January, March, April, May and July 2015. The last review of the nutritional assessment was dated 02 February 2015 and stated the person had a normal diet and required the assistance of one care worker to eat. The assessment stated the person had no chewing or swallowing difficulties and the score was 0 which equated to low risk. The assessment had not been reviewed to take account of the fact the person had lost 2.3kg between February and August 2015. The person had a nutrition care plan which stated a diet and fluid chart should be completed after each meal. We looked at the food/fluid chart dated 15 August 2015; there was one entry at 7:15am which stated the person had a full bowl of porridge and 200mls of coffee. The chart dated 13 August 2015 stated the person had three quarters of a portion of sausage, mash and veg, jam roly poly and 300mls of tea at 11am. There was no other entry for that day. There were no records for 02, 05, 10, 11 and 15 August 2015.

In another person's records we saw they had lost 3.9kg between February 2015 when their weight was 76.3kg and June 2015 when it was 72.4kg. There was no record of the person's weight having been checked since June 2015. There was an entry on the Waterlow assessment (used to assess the risk of developing pressure sores) dated 21 May 2015 which stated the person had a BMI which was "still quite high" and the person's weight loss was attributed to them having a well-balanced diet rather than the "snacky" foods such as chocolate which they had been eating at home. The care plan dated 09 February 2015 stated to offer the person well balanced diet and fluids. It had not been changed in response to the person's weight loss. The professional visits record showed visits from the district nurses and GP but there was no record the person's weight loss had been discussed. There was an entry dated 22 June 2015 which stated diet and fluid charts were no longer needed.

We found similar concerns in the records of the other five people who had lost weight or were nutritionally at risk. The care plans and risk assessments were not up to date, where food charts were in place they were incomplete and in some cases there were no records to show why food/fluid monitoring charts had been stopped.

Inadequate

Is the service effective?

We concluded the provider was not providing people with appropriate support to meet their nutrition and hydration needs. Following the inspection we raised a safeguarding alert with the Local Authority in respect of the concerns we had about people's nutritional needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the cook. They told us the special diets they prepared were for people with diabetes and people who needed a pureed diet. They told us none of the people living in the home at the time of the inspection were following special diets because of their culture or religion. The cook told us they did not know about people who had a low weight but they did know who liked small or large portions. They told us they used full fat milk, butter and cream in all the meals and added cream to soup. They said they didn't make their own soup but did home baking. They told us there was a set meal at lunch time but people could have an alternative if they wanted. They said care staff had access to the kitchen at night and although they didn't prepare anything for supper people could have whatever they wanted.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us one person had a DoLS authorisation in place. They said they had submitted applications for DoLS authorisations for a number of other people but had not been notified of the outcome. We looked at the records of the person who had the DoLS authorisation in place. The authorisation had been granted in June 2015 with conditions about completing a personal profile and devising a care plan for social activities. There was no evidence in the person's care records to show this had been done. We asked the registered manager about this and they said they had asked the person's relatives to provide information but they had not received anything.

During the inspection we observed one person who used the service talked repeatedly about leaving the home. The staff used different approaches to divert the person's attention but throughout the day they continued to talk about leaving. We looked at the person's care records and saw this was not an isolated event, the person frequently talked about leaving the home. Their mental health care plan had last been reviewed on 30 June 2015 and stated a DoLS application had been submitted in November 2014 and the registered manager was going to chase this up. We asked the registered manager about this and they said they had still not had a response. We asked if they had considered an urgent application and they said all the applications they had submitted had been urgent. In certain circumstances the managing authority, which in a care home is the registered person can grant an urgent authorisation.

One the staff we spoke with told us they had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards. They had a good understanding of the MCA and DoLS however they told us they thought there were three people who had DOLS in place because they often tried to leave the building. There was only one person who had a DoLS authorisation in place.

This meant there was a risk that people were being deprived of the liberty unlawfully.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had access to a range of NHS services such as GP, district nurses and community mental health care staff. However, when we looked at how a how people were supported to meet their health care needs we found people were not being supported to access the services of a dietician. This meant there was a risk people would not receive appropriate care.

Inadequate

Is the service effective?

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

The home used a Telemedicine system which provided a video link to the local hospital. This enabled people to have a medical assessment without going to the Accident and Emergency department. This helped to reduce unnecessary hospital visits which can be distressing particularly for people living with dementia.

The registered manager told us all new staff received induction training and shadowed more experienced members until they were competent and confident to work on their own. The registered manager said the time spent shadowing depended on the individual and their previous experience. All new staff completed an in-house induction programme and until recently the service had used an external training provider for induction training. At the time of the inspection they had implemented the new Care Certificate induction training programme. One of the staff we spoke with told us they were doing the Care Certificate on line and were about half way through.

The training records showed staff received training on safe working practices such as moving and handling, fire safety, infection control and food safety. However, one of the staff we spoke with told us they had been working there three months and had not been shown the fire procedures and had not had fire training. This was discussed with the registered manager who said they would deal with it.

We looked at the training records of 20 staff including the registered manager and saw that just under half had attended training on supporting people living with dementia. The records showed senior staff had received training on the safe management of medicines. In one person's care records we saw a recommendation had been made in July 2015 about providing staff with training on control and restraint. We asked the registered manager about this and they told us they were still trying to find a suitable training course.

The registered manager told us there was a planned programme of staff supervision and appraisals, they said the appraisals were a bit behind schedule but they were dealing with it.

Requires improvement

Is the service caring?

Our findings

There were some aspects of the way the service was organised which did not promote a person centred approach to care. For example, the way care and support was organised for people who needed help to eat and drink. People who needed help to eat and drink starting having their breakfast from 05.30am onwards, had lunch at approximately 11am and had their evening meal at approximately 4pm. Staff we spoke with talked in terms of "starting to feed the early sitting" mid-morning and starting the "early feed" at 4pm. This risked creating a culture where the delivery of care became a series of tasks to be completed rather than in response to people's individual needs. This meant there was a risk people would not receive care which was appropriate, met their needs and reflected their preferences.

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

During the inspection we observed a lot of positive interactions between staff and people who used the service. Staff spoke with people kindly and were compassionate and there was a lot of friendly banter between staff and people living at the home. It was evident staff knew people and were able to talk with them about their family, friends and interests.

People we spoke with said the staff were caring and friendly and one person described the staff as being, "Wonderful." The relatives of one person who lived at the home told us they had no concerns and were kept informed about any changes to their relatives care; they said the staff, "Do their best."

When we looked around we saw people had personal belongings in their rooms which showed they were supported to individualise their personal space and keep in touch with their family, friends and interests.

The registered manager told us advocacy services were arranged for people when they did not have anyone to represent them and were unable to advocate on their own behalf.

Inadequate

Is the service responsive?

Our findings

On the second day of the inspection we observed people's care using the SOFI (Short Observational Framework for Inspectors) tool. We carried out the SOFI observation between 11.30am and 12 midday in the front lounge. At the 11.30am there were eight people in the room and they were all asleep. There was motor racing on the TV and there were no staff present. We saw people did not have drinks and there were no drinks available. We observed four people using the SOFI tool. Two of the four people we observed did not have any interactions with other people in the room or staff during the 30 minutes. Positive interactions are important because they enhance people's feelings of wellbeing. We saw two people had interactions with staff which were positive. In addition to the four people included in the SOFI observation we saw a person who used the service was shouting for help, there were no staff in the lounge and we had to go and find a member of staff to help them. There was one call bell in the lounge but it was behind a chair and not accessible to people. Just after 11.30am staff brought a person in a wheelchair into the lounge. Two separate staff told the person they would help them out of the wheelchair into an armchair in a minute. After 30 minutes the person was still in the wheelchair. This showed us staff were not always responsive to people's needs.

In the records of one person who had moved into the home shortly before the inspection we found the pre-admission assessment records were incomplete. There was very little information about the person's care needs and it was not clear when the assessment had been carried out. There were no initial care plans in place to inform staff about the person's care and support needs. This meant there was a risk the person would not receive care which was appropriate and met their needs.

In two other people's records we found the pre-admission assessment booklets were blank. This meant there was no evidence to show how the provider had assessed the person's care needs before they moved in to make sure they were able to meet the person's needs.

In the case of another person who used the service we found no assessments of the person's needs had been carried out and there were no care plans in place. The registered manager told us the person had been coming to the home for periods of respite care (short stays) for years and confirmed there were no documented assessments or care plans in place. The person's daily care records showed they required support in a number of areas, such as mobility, eating and drinking and pressure area care. The absence of assessments and care plans meant the person was at risk of not receiving care which was appropriate, met their needs and took account of their preferences.

In another person's records we saw they sometimes presented with behaviour which was challenging. There was no care plan in place to guide staff on how to manage this behaviour to ensure the person received appropriate care.

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

In one person's records we saw a falls assessment had been completed on 17 April 2015 which identified the person had a low risk of falling. The assessment stated the person put themselves on the floor but sustained no injuries. The care notes showed the person had been found on the floor in their room on two separate occasions in the two weeks before the assessment; the records stated this was not witnessed therefore it wasn't clear how staff could be sure the person had not fallen. On the first occasion the records showed the person was found to have a red mark on their neck. The records for May 2015 showed the person had unexplained skin tears on one occasion and on another occasion had an unobserved fall which resulted in a head injury. The paramedics had been called and the person had been taken to hospital for assessment and treatment. The falls risk assessment had not been updated in response to these incidents which created a risk of the person not receiving appropriate care to maintain their safety.

In another person's records the falls risk assessment had been reviewed in January and May 2015 and showed the person had a pressure mat in place to alert staff when they got out of bed. An accident report dated 18 July 2015 showed the person had fallen in their bedroom and had been found by staff when they were doing routine checks. We asked the registered manager if the pressure mat had not worked to alert staff the person was out of bed. The registered manager said the pressure mat had been

Inadequate

Is the service responsive?

removed because it had added to the person's confusion. This was not reflected in the records and there was no evidence alternative measures had been put in place to manage the risk of falls.

This was a breach of Regulation 17 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed an activities organiser who worked four days a week organising social activities for people. There was also a weekly exercise group and bi weekly music and reminiscence group facilitated by external agencies and the registered manager told us they had external entertainers at least once a month. In addition, the home had a volunteer who worked mainly with individuals and supported people to go out to the local shops and markets.

The registered manager told us there had not been any complaints since March 2013 when the complaints records had been looked at during a CQC inspection. There was a complaints procedure in place and information about this was included in the people's contracts, the service user guide and the home's brochures.

Inadequate

Is the service well-led?

Our findings

The provider sent survey questionnaires to people who used the service and/or their representatives annually. In June 2015 the provider sent out 28 questionnaires and 10 were returned. The feedback was positive and comments included, "Always made welcome", "I feel the staff do a great job" and "Staff are always cheerful and welcoming". One person had commented that the laundry service could be better; the registered manager told us they had addressed this concern and added if items of clothing were damaged in the laundry they would replace them.

The provider did not have meetings for people who used the service and/or their representatives. The registered manager told us they had tried this in the past but it had not been successful. They told us they encouraged people to take part in individual care reviews which took place at least once a year but more typically every three to four months.

The provider had a quality monitoring system in place. This included an annual audit carried out by an external agency. The most recent external audit was carried out in May 2015 and did not identify any shortfalls in the service. However, we had concerns about the effectiveness of the provider's processes for checking and monitoring the quality of the services provided because they had not identified the concerns we found during the course of the inspection.

We found the provider did not maintain accurate and complete records in respect of the care and treatment provided to people who used the service.

The records relating to the management of medicines were not complete. For example, we found gaps in the medication administration records which meant we could not be assured people had received their prescribed medicines. We have outlined our concerns in more detail in the safe section of this report.

We found the records relating to how people were supported to meet their nutritional needs were incomplete. As detailed in the effective section this report we found peoples nutritional risk assessments and care plans were not complete, accurate and up to date. We found the food and fluid charts had not been completed properly which meant it was not possible to see how much people had actually had to eat and drink.

When we looked at people's care records we found several examples where there were no entries in the daily and nightly care reports to show what care, treatment and support people had been provided with. For example, in one person's records we found there were no daily care notes recorded on the 6, 7 and 13 August 2015 and on 7, 8, 9, 10 July 2015. In the same person's records there were no night reports recorded on 6 August 2015 and 11 and 12 July 2015. In another person's records there were no day reports recorded on 8 April 2015, 7 May 2015, 12 and 23 June 2015, 3 and 9 July 2015 and 8 August 2015. There were no night reports recorded on 11 and 12 April 2015 and there was no entry, day or night, for 26 May 2015. In the records of another person there were no daily care reports for 23, 24, 25, 27, 29 & 30 May 2015 and 02 June 2015.

In one person's records we found the pre-admission assessment document had not been completed properly and there were no care plans in place to inform staff about the person's care and support needs. This meant there was a risk the person would not receive care which was appropriate and met their needs.

When we asked the registered manager about the shortfalls in record keeping they told us the staff were too busy to complete the records. The registered manager said they were satisfied the staff were delivering appropriate care and did not accept that the shortfalls in the records posed a potential risk to people's health, safety and welfare.

We found the provider did not have effective systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service and others.

As detailed in the safe section of this report we found the provider did not have effective systems and processes in place to safeguarding people from abuse and/or the risk of abuse and safeguarding concerns were not identified and reported correctly.

In addition, we found people who sometimes presented with behaviour which challenged did not care plans in place to guide staff on how best to support them and protect other people. We found risk assessments and care plans for the management of people who were at risk of falling were not up accurate and up to date and did not show what actions were being taken to manage the risk. We have included more information about this in the responsive section of this report.

Inadequate

Is the service well-led?

We found the provider did not have effective systems and processes in place to assess, monitor and improve the quality of the services provided. For example, at two previous inspections in May and December 2014 we issued compliance action because the provider had failed to ensure people were protected against the risks associated with the unsafe management of medicines. During this inspection we found the provider had not taken appropriate action to address this breach of regulation and the required improvements had not been made.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 **People did not consistently receive care and treatment which was appropriate, met their needs and took account of their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered persons did not have effective systems and processes in place to protect service users from abuse or the risk of abuse.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons did not have systems and processes in place to ensure the safe and proper management of medicines.

The enforcement action we took:
Warning notice to be met by 23 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service were not consistently met.

The enforcement action we took:
Warning notice to be met by 23 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered persons did not have effective systems and processes to ensure compliance with the regulations by means of assessing, monitoring and improving the quality and safety of the services provided, assessing, monitoring and mitigating risks relating to the health, safety and welfare of service users and others and maintaining accurate, complete and contemporaneous records in respect of each service user.

The enforcement action we took:
Warning notice to be met by 23 December 2015