GCH (West Drayton) Ltd

Drayton Village Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced inspection of Drayton Village Care Centre on the 25, 26, 27, 28 and 29 April 2016.

Drayton Village Care Centre is a nursing home and is part of Gold Care Homes. It provides accommodation for up to 59 older people in single rooms. The home is situated within a residential area of the London Borough of Hillingdon. At the time of our visit there were 57 people using the service.

We previously inspected Drayton Village Care Centre on 29 and 30 January 2015 and we identified areas for improvement in relation to medicines management, staff training and supervision, and the Mental Capacity Act 2005.

At this inspection we found the provider had made some improvement but there were still areas for improvement with staffing training, supervision and appraisals.

The service had a registered manager in place but at the time of the inspection the registered manager was on extended leave. An interim manager had been in place at the home for four weeks. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a recruitment process in place but this had not been followed in relation to obtaining references which provided appropriate information on the applicant's skills and experience.

Chemicals used for hairdressing and cleaning were not stored securely and there was a risk of cross contamination as equipment used to move people was stored in two bathrooms.

The provider had a process in place for the recording and investigation of accidents and incidents but this had not always been followed by the registered manager.

Risk assessments did not provide up to date information in relation to individual's risks when receiving care.

There was a policy and procedure in place for the administration of medicines and they were stored safely but the administration of topical creams was not recorded accurately.

Staff had not received the necessary induction, training and support they required to deliver care safely and to an appropriate standard as identified by the provider.

There were not always enough staff to meet people's care needs appropriately and safely.

Care workers were sometimes busy which resulted in them not appropriately supporting people's emotional and social needs as they were focused on tasks.

Care plans were not written in a way that identified each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

Activities were organised at the home but some of these were not meaningful for people and when the activities coordinator was unavailable there were limited activities organised.

The provider had a process in place for responding to complaints but this had not always been followed by the registered manager.

The records relating to care of people using the service did not provide an accurate and complete picture of their support needs.

The provider had a range of audits in place but these had not been carried out regularly to identify aspects of the service requiring improvement and action had not always been taken to address issues.

Care workers and nurses demonstrated a good understanding of the importance of supporting people to maintain their independence.

The provider had policies, procedures and training in relation to the Mental Capacity Act 2005 and care workers were aware of the importance of supporting people to make choices.

Each person using the service had an evacuation plan in place in case of an emergency. People felt safe when they received care and support.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider for a breach of the Regulations in relation to person-centred care (regulation 9), dignity and respect (Regulation 10), the safe care and treatment of people using the service (Regulation 12), receiving and acting on complaints (Regulation 16), the good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper persons employed (Regulation 19). You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The provider had a recruitment process in place but this had not been followed in relation to obtaining references.

Chemicals used for hairdressing and cleaning were not stored securely and there was a risk of cross contamination as equipment used to move people was stored in two bathrooms.

Risk assessments did not provide up to date information in relation to individual's risks when receiving care.

The provider had a process in place for the recording of incidents and accidents but this was not always followed.

There were not always enough staff to meet people's care needs appropriately and safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff had not received the necessary induction, training and support they required to deliver care safely and to an appropriate standard.

The provider had a policy in relation to the Mental Capacity Act 2005. We found the service had made appropriate applications to meet the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA)

There was a good working relationship with health professionals who also provided support for the person using the service.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Sometimes when care workers were busy they did not appropriately support people's emotional and social needs as they were focused on tasks.

Care workers and nurses demonstrated a good understanding of the importance of supporting people to maintain their independence.

Care workers and nurses explained how they helped people maintain their privacy and dignity when they provided care.

Is the service responsive?

Inadequate

The service was not responsive. Care plans were not written in a way that identified each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

The provider had a complaints procedure in place but some complaints had not been responded to in line with their procedure.

Activities were organised at the home but some of these were not meaningful for people and when the activities coordinator was unavailable there were limited activities organised.

Is the service well-led?

Inadequate

The service was not well-led. Records relating to care and people using the service did not provide an accurate and complete picture of their support needs.

Records of training, supervision and appraisal for staff at Drayton Village Care Centre did not provide current accurate information.

Regular audits had not been carried out to identify aspects of the service requiring improvement and action had not always been taken to address issues.

Drayton Village Care Centre

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 the 25, 26, 27, 28 and 29 April 2016. The first day of the inspection was unannounced with the following days being announced. During the inspection period the home was visited by three inspectors, a pharmacy inspector, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection had personal experience of caring for people who had dementia.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with 13 people using the service, eight relatives and seven care workers and nurses. We also spoke with the interim manager, regional manager, group operations manager and the provider's care quality support worker. We reviewed the support plans for 10 people using the service, the daily records of care for five people, the employment folders for six care workers, the training and support records for 61 staff and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The provider had a recruitment process in place but we found this was not always followed. The interim manager explained applicants were asked to provide two references. During the inspection we looked at the recruitment records for six members of staff. We saw the recruitment paperwork for one applicant showed the provider had received two references which were from the same person but with different wording. This person was not the applicant's previous employer and their relationship with the applicant was not recorded. As part of the interview process people applying for specific roles were required to complete a set of questions to check their knowledge in relation to social care. We saw that this applicant had not completed the majority of questions to demonstrate their knowledge and understanding of issues included safeguarding and medicine administration practice. For another applicant we saw that one reference had been received before they had started their role but their second reference was received four months after they started their role. The second reference did not indicate clearly who it was from and their relationship to the applicant. The recruitment paperwork for a third applicant identified the overseas contact details of people from their previous employment who could provide references. We saw that two references had been received from personal email addresses and these references contained one line of comment which did not provide feedback on the person's ability to provide safe care and did not identify their relationship to the applicant. The registered manager had not checked the references to ensure they had been provided by the people identified on the application form.

This meant that the provider could not ensure that care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable references had not been obtained.

The above paragraphs demonstrate a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection we found chemicals were not stored safely around the home and could be easily accessed by people living at the home. In the hairdressing room we found hair setting lotion, nail varnish remover and other hair styling products which were stored on a worktop or in a trolley. The room could not be locked and the products were not kept securely in the room. In the two dining rooms we found surface cleaning spray, washing up liquid, cream cleaner, toilet cleaning tablets and an unidentified white cleaning powder in an open container which were stored in a cupboard under the sink. These cupboards could not be locked and people could access them without the support of a care worker. This meant that people were at risk of being able to access chemicals that could be dangerous. We identified these issues with the interim manager and all the items were removed to be stored securely.

The above paragraph demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we found equipment used for moving people was stored in two bathrooms on the first floor unit. We spoke with staff who confirmed that the baths and shower were not regularly accessed but the toilets in both bathrooms were used by people using the service. In one bathroom we saw two hoists, seated

weighing scales, one wheelchair and a walking frame. In the other bathroom we saw two hoists, two walking frames, and one wheelchair. The equipment in both bathrooms was stored next to the toilet which increased the risk of cross infection. This equipment was used regularly by care workers. During the inspection we also saw glove dispensers were mounted on the wall around the home. We saw that the glove dispensers were often empty which meant that care workers could not easily access personal protective equipment.

The above paragraph demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a process in place for recording and investigating accidents and incidents but this was not always followed. The interim manager explained the care worker or nurse would complete a record form if an incident or accident occurred. They needed to include information about the event, who was involved and what action was taken. As part of the provider's process the registered manager needed to review the form, check to see if the care plan had been updated, if any notifications had been made to external organisations and describe the investigation and any action taken by the manager. During the inspection we looked at 16 incident and accident record forms. We saw 11 record forms had not been completed in full because the registered manager had not recorded that they had reviewed the information, the results of any investigation or actions taken. One form included a record of actions but was not signed or dated by the registered manager to show they had seen the form. This meant that incidents and accidents were not being monitored so any trends could be identified and checks could not be made to ensure appropriate actions were taken to reduce the risk of the event occurring again. We looked at four records that had been completed since the interim manager had been in post and these had been completed in full and reviewed by the interim manager.

The above paragraph demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks to people's safety and wellbeing had been assessed, but these assessments were not always reviewed and therefore information did not accurately reflect people's needs. Risk assessments in relation to pressure ulcers, falls and malnutrition were in place and the interim manager confirmed these should be reviewed monthly, however this had not yet happened. For example, the moving and handling risk assessment and the continence risk assessment for one person had not been signed or dated. Therefore, the date of the assessment could not be identified. We saw the general risk assessment for another person was dated May 2015. This had not been reviewed since and therefore changes in this person's needs had not been recorded. Records indicated that one person had fallen on a number of occasions in 2016, however their risk assessment relating to falls had not been reviewed since December 2015. This meant information about these falls and ways to prevent further accidents had not been recorded. The falls risk assessments for another person had been completed in August 2015 and had been reviewed once in February 2016. A risk assessment relating to catheter care for one person was last reviewed in February 2016. The falls risk assessment for another person had not been reviewed since December 2015 and they were assessed as being at high risk of falls.

The wording used in some risk assessments to describe a specific need was not appropriate. We saw one person had a risk assessment titled 'Wandering' which referred to the person having difficulty finding their way around familiar environments. The risk assessment was dated April 2015 and had not been reviewed. The risk assessments did not always include a clear plan to support the person. For example, one risk assessment stated care workers should 'identify and control wandering triggers' and provided a list of possible triggers including going to the toilet but did not explain how these should be resolved. A second

risk assessment referred to a risk of absconding and we saw both risk assessments advised care workers to ensure all doors were locked. This risk assessment was dated September 2015 and had not been reviewed. Risk assessments did not adequately describe individual needs and how to support people. This meant that care workers were not always aware of any increased risk in relation to the person's support needs and how to reduce these risks as the assessment did not provide a current picture of the support needs. The interim manager confirmed the risk assessments were generic and a new format for risk assessments was being introduced during May 2016.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked care workers and nurses if they thought there were enough staff to provide appropriate levels of support and we received mixed feedback. They told us "We could do with more staff on the first floor in the morning because we are quite busy then. Three or four people call out at the same time and we only have basic staffing levels. Two staff should do hoisting and the nurse does medication" and "Before there were not enough staff but management have hired more staff. The first floor used to be tough but things are beginning to look up now." Other comments included "There are always two nurses on shift and a manager. The staff to people ratio is enough to provide for people's needs. Six or seven people need double-up care out of twenty four or twenty five people on the first floor", "The staff team works well together. In the morning we make a plan and divide up the hoisting of people to balance things. All staff know what tasks they need to do. There is very good co-ordination. The nurses come to help us" and "Yes, there are enough staff to meet people's needs. There are five carers and two nurses on the first floor."

The interim manager confirmed there was one senior care worker and three care workers during the day on the residential care unit on the ground floor with one senior care worker and two care workers at night. On the nursing unit located on the first floor there were two nurses and five care workers on shift during the day and one nurse with two care workers overnight. We received the assessments of each person's dependency levels which identified if the person required one or two care workers to provide them appropriate support following the inspection. We saw six people required the support of two staff members on the ground floor while on the first floor 20 people needed the support of two care workers when receiving care.

During the inspection we saw that care workers had a large workload on the first floor unit and appeared to be unable to spend time with people in the lounges especially during breakfast as they were busy providing support during personal care. To provide personal care for 20 people it could take four care workers over two hours. The interim manager explained they had recently implemented a new system on the first floor to enable care workers to provide additional support for their colleagues when required.

Therefore the provider had acknowledged that they did not have enough staff on duty to meet people's needs at the time of the inspection. This meant that people had to wait for the care they needed.

The above paragraphs demonstrate a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our comprehensive inspection of Drayton Village Care Centre on 29 and 30 January 2015 we found that medicines were not being recorded correctly when administered.

At the inspection in April 2016 we saw nurses and care workers giving people medicines in a safe and caring manner. Medication administration records (MAR) were clear and contained information to support staff such as allergies and dose changes. Since the last inspection we saw that improvements had been made in

the recording of medicines administered and all the medicines we checked had been signed for or noted with a code to show why it had been omitted, for example where the person refused. Medicines that needed to be given at set times were recorded correctly on the MAR and we saw that they were given appropriately. Where medicines were prescribed 'as required' we saw that individual protocols had been prepared to support staff to give the medicines when they were needed. External preparations were recorded on a separate sheet for each person; however some of these were incomplete. We discussed this with the interim manager who explained the format of records was being changed and care workers would be reminded to complete the records appropriately.

Medicines were available for people when they needed them and were stored securely, including controlled drugs. Staff kept appropriate records of all medicines, including those for destruction. We saw that all care workers who administered medicines had received training and had undertaken a recent competency assessment. Regular audits were completed and we noted that actions from the audits were taken forward. For example we saw a regular check that all 'when required' protocols were in place and actions taken to prompt the GP to do medication reviews.

We saw each person had an evacuation plan in place in case of an emergency which provided care workers with guidance on what action should be taken to support the person appropriately. The plan also identified specific needs which may impact on the evacuation of the person from the home including mobility and health conditions. The plans were kept in the main reception area of the home. We saw some of these plans had not been regularly updated with some documents stating they should be reviewed monthly while others stated quarterly reviews. We raised this with the interim manager who explained they were in the process of updating them and they would all be reviewed every six months.

People we spoke with said that they felt safe when they received support from the care workers. We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. We looked at the records of safeguarding concerns and we saw that information relating to the concern, notes of the investigation, any actions taken and the outcome were not always recorded. We discussed this with the interim manager and they confirmed any information that was required to identify the outcome of the safeguarding investigation would be located and added to the record.

Requires Improvement

Is the service effective?

Our findings

During our comprehensive inspection of Drayton Village Care Centre on 29 and 30 January 2015 we found that people were being cared for by care workers who were not supported to deliver care and treatment safely and to an appropriate standard as they did not receive the necessary training, supervision and annual appraisals.

At the inspection on 25, 26, 27, 29 and 29 April 2016 we found that improvement had not been made in relation to the levels of training, supervision and appraisals.

The interim manager provided us with records of the completed training that was identified as mandatory by the provider. The interim manager also explained that as part of the induction for new staff they should complete the mandatory training courses for safeguarding vulnerable adults, fire awareness, moving and handling and health and safety. We saw the training records of eight nurses, one unit manager, three senior care workers, 34 care workers including nine bank staff and 15 housekeeping and kitchen support staff. This included staff who had started working at the home since 1 January 2016 and should have completed their training during induction.

In relation to mandatory training which was identified as requiring to be completed annually we saw three nurses, three care workers and four support staff had not completed the moving and handling training. Two care workers had not completed a refresher course within the provider's required timescale. There was one nurse, seven care workers and one member of support staff who had not completed the training during their induction.

In relation to fire awareness training three nurses, 11 care workers and three support staff had not completed the training. Two nurses, ten care workers and two support staff had not completed the training during induction.

We saw three nurses, five care workers and four support staff had not completed safeguarding vulnerable adults training. We also saw three care workers had not completed the annual refresher course. There were two nurses, 11 care workers and two support staff who had not completed the course during their induction.

The health and safety training course had not been completed by one unit manager, four nurses, two senior care workers, 14 care workers and nine support staff. We saw that two nurses, 14 care workers and two support staff had not completed the training during induction.

The provider also identified mandatory training that was required to be completed every two years. We saw that six nurses, 21 care workers and four support staff had not completed the infection control training.

In relation to Mental Capacity Act and Deprivation of Liberty Safeguards we saw that eight nurses, 27 care workers and five support staff had not completed the training. There was one care worker that had not

completed the refresher course.

We saw the Control of Substances Hazardous to Health (COSHH) training had not been completed by seven nurses, two senior care workers, 29 care workers and five support staff.

We saw one unit manager, seven nurses, three senior care workers and 28 care workers had not completed the food hygiene training course.

Six nurses, two senior care workers and 25 care workers had not completed the first aid awareness course.

This meant that nurses, care workers and other staff had not received suitable training and support to enable them to provide appropriate and safe care for people using the service.

During the inspection we looked at the employment records for two nurses, two care workers and one member of housekeeping. We saw the induction records for one care worker had been completed in one day instead of the scheduled three days. No records had been made in relation to the care workers competencies during any assessments. The induction record for a member of housekeeping staff showed that the training on dealing with cleaning chemicals had not been completed until a month after they had started work. We were unable to locate any completed induction workbooks in two employee records we looked at and the interim manager explained that it was up to the individual staff member to return their completed document. This meant that the individual staff member's competency to carry out their role could not be reviewed during their induction period.

The interim manager provided a record of the supervision sessions for staff completed since the previous inspection. The interim manager explained there was an expectation that six supervisions were carried out each year. These could include face to face meetings with a line manager, observation of work practice and an annual appraisal. The records for 2015 showed that 24 staff members had completed a maximum of two supervision sessions during the year. Since the start of 2016 three staff members had completed one supervision session with a further six supervision sessions occurring during the inspection. The interim manager confirmed that only 10 staff had received an appraisal during 2015.

This meant that care workers and other staff had not received suitable induction, training and support to enable them to provide appropriate and safe care for people using the service.

The above paragraphs demonstrate a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

During the inspection the interim manager showed us a list of all the people at the home for which

applications for DoLS had been made. This record showed the date of the initial application, when it was authorised and the expiry date. We saw that the date the application ended and when a reapplication was due were also recorded. The interim manager explained that the date a reapplication was sent was recorded with the new date of authorisation. We saw that all the applications were up to date and the DoLS paperwork for each person was kept in the manager's office.

We asked people using the service and relatives their views on the food provided. People told us "The food is OK. I don't eat enough; they are always trying to get me to eat more", "The food is quite good. You can have whatever you want for breakfast. I think lunch is more or less a set meal" and "The food is usually quite good. You get a choice." Another person said "They bring me fresh fruit every day. I have the fruit because I ask for it." The person also explained that they could make themselves a cup of tea if they got up early and "later on they bring me toast." Other people said "I complained about the food at the residents' meeting in December and there has been a great improvement since" and "The food is reasonably good." A relative told us "I've been fighting for months for good quality food that my family member likes and served with not too much on the plate. They promised fresh fruit in my relative's room in March and little things to tempt and encourage them to eat but it has not happened."

During the inspection we saw that menus identifying the meal options for each day were not displayed and the care workers were unaware of the options when asked. The interim manager explained that they had been working with the people living at Drayton Village Care Centre to identify their preferred food options to develop a new range of menus which would be introduced in May 2016. We also saw a picture based menu cards system was being developed to be used in the dining rooms. The interim manager told us that care workers should show the people in the dining room the two meal options plated so they could choose. When we observed meals in the dining rooms this did not always happen and we discussed this with the interim manager who confirmed they would remind the care workers to ensure this occurred at during every meal. We saw that peoples' dietary requirements related to both medical needs and religious beliefs were identified and met.

One person told us "You can see a doctor if you want." We saw there was a good working relationship between the service and health professionals who also supported the individual. The care plan folders we looked at provided the contact details for the person's General Practitioner (GP). There was a record of professional visitors in each person's care folder which included visits by the General Practitioner (GP), district nurse and chiropodist.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service their view on the care workers and nurses at the home. They told us "The staff are competent and caring. I have no complaints at all about any of the staff members…. I am able to chat with them about things; 'outside' things" and "You can't fault the carers. They do their best here."

In general people were cared for by kind and gentle staff. Throughout the inspection we saw examples of care workers and nurses having an understanding of people's specific needs and they knew how to communicate appropriately with the people they supported. However, there were times during the inspection when the care workers and nurses were unable to support a person's emotional and social, in addition to their physical needs, as they were busy completing other tasks or they had not identified an occasion when people may feel isolated and bored.

We saw over a number of days on one unit during the breakfast period people were taken to the lounge once their personal care had been completed to wait for breakfast to be served. On one occasion we saw a care worker brought a person into the lounge to wait for breakfast. The person sat in an armchair and fell asleep and had no contact with staff for almost an hour. A nurse came into the lounge to administer the person's medicines and woke them up. They asked the person if they had eaten breakfast but the person was confused as they had just woken up and did not respond clearly. At this point we intervened and informed the nurse the person had not yet had their breakfast. The nurse then took the person to the dining room. At other times during the inspection we observed people were in the lounge and care workers did not come into this room for more than 45 minutes. On one occasion we saw a care worker enter the lounge and put the television on without asking people if they wanted it turned on and then selected a channel without involving people in the decision. The care worker then left the lounge with the remote control left next to the television so people were unable to change the channel.

During the inspection we saw people eating their lunch in a dining room with care workers providing support on one of the units. We saw one person was brought into the dining room by a care worker and their clothing was secured so the person's incontinence protection could be clearly seen. A nurse adjusted the person's clothing but it was still visible. During the meal the care workers were discussing who required support to eat their lunch in their room. The conversations were carried out across the dining room over the people eating their meal. Care workers were using phrases like "When you have done [person's name] can you go and do [person's name]", "I don't know [person's name] or what they need" with the response "Just go and feed [person's name]" and "When I have done [person's name] I will do [person's name]."

During the meal we also saw one person remove their dentures and place them on their plate. The care workers did not notice this and the person was having difficulty cutting up the meat during the meal. Throughout the meal they were moving their dentures around the plate with a fork so they could get to the food. When the person had finished eating a nurse saw that their dentures were on the plate as they were clearing away. The nurse picked up the dentures and put them back in the person's mouth without washing them as they were covered in gravy.

Throughout observations during the inspection we saw there were times that the care workers and nurses on one unit became entirely focused on the tasks they had to complete and their allocated task did not include spending time with people in a social setting. People's physical needs were not neglected but there were occasions where their social and emotional needs were not met.

The above paragraphs demonstrate a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the care plans we looked at identified the person's cultural and religious needs. Some of the care plans we looked at also included information on the person's life history and family.

We asked care workers and nurses how they helped people maintain their privacy and dignity when providing care. A care worker said "All staff call people by their preferred name. We make sure doors and curtains are closed when providing personal care. We cover the person when we are washing them. We help people to be dressed properly and ask them how they want to be dressed. You must go to a person's room to help them with dressing and personal care". We encourage choice and we don't impose our beliefs on people". Nurses told us "Staff have had training in this. We knock before going into people's rooms. We greet people respectfully and call a person by their preferred name. We respect people by giving them choices and respecting these so respecting their views. We close windows when attending to care and make sure the curtains are drawn. There must be privacy for all care. If people knock, we tell them to hold on as the person is having personal care" and "It is about keeping people's secrets. Their door must be shut during personal care. Don't let any of their private information leak out except with the consent of the patient." Another care worker told us "Be respectful to people - these people were once great and important people. Make sure people feel they are still important."

Care workers and nurses we spoke with demonstrated a good understanding of the importance of supporting a person to maintain their independence. One care worker told us "We encourage people to do things for themselves. We give people the maximum time we can to show us they are independent. We encourage people to make choices, for example help a person to walk if they are sitting all the time." Nurses said "Need to assess the individual and know their needs. Then make a care plan with aims and actions. Everybody will know about the care plan. Need to review the care plan accordingly – do this at handovers between nurses then give the care plans to HCAs to read" and "It's helping people take care of their hygiene needs and assisting with feeding. We encourage people and supervise them so they are safe, for example when they are walking. When washing people, encourage them to wash themselves as much as they can." Another care worker said "It's getting the person involved. Give the person certain tasks to do each day and promoting that. But you still need to watch them."

Inadequate

Is the service responsive?

Our findings

The care plans we looked at had been reviewed monthly but were not written in a way that identified each person's wishes as to how they wanted their care and support to be provided. The majority of care plans we looked at did not provide any specific detail as to how the person wanted their care provided. Each person had a folder containing care plans relating to aspects of daily care and the person's support needs. Each separate care plan described the tasks the care workers needed to complete to provide people with their daily care but did not specifically describe the individual person's preferences, for example what time they wanted to get up in the morning, the type of clothes they usually wore and their preference for personal care. The care plans for one person were more detailed and the interim manager explained that these had been written using a different care plan format. The interim manager confirmed that new care plan formats were being introduced from May 2016 which would be more focused on the person's wishes and how they could influence daily care tasks.

Where a person had a Deprivation of Liberty Safeguard authorised there was no information about this, the conditions which had been made and what they related to in their care plans. The impact of the DoLS was not reflected in the care plans and did not provide guidance for the care worker as to how appropriate care and support should be provided. We looked at the care plan folder for one person who had a DoLS authorised and saw their mental health care plan was blank and there was no reference to the DoLS in any other section of the care plan. A copy of the DoLS authorisation was located in the back of some of the folders we looked at.

The care workers completed daily records of care and support provided for people using the service. The records we saw were focused on the tasks completed by the care worker and did not provide information relating to the person's experiences and feeling during the day. This did not provide a complete picture of the person during each day.

We saw the care plans did not indicate that the person living at the home or their relatives were involved in the development of, or during the monthly reviews of the plans. One person we spoke with confirmed that they were unaware of their care plan and a relative told us their family member's care plan had not been reviewed for more than a year. The interim manager confirmed that care plans had previously been developed using the information from the initial assessment of the person before they moved into the home and were not written with the person they related to. They explained that the implementation of the new care plan format would be carried out with people using the service and relatives to ensure they wishes and care needs were identified.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a procedure in place to respond to complaints but we found this was not being followed. During the inspection we looked at the records for complaints that had been received during the previous year. We looked at three separate complaints and saw the registered manager had responded to the

relatives in relation to the complaint they had raised and it had been closed but there was no confirmation that the complaints had been resolved to the relative's satisfaction. We looked at other complaints that had been received and saw that some had been received over six months before and had not yet been resolved. The interim manager confirmed they were responding to complaints that had been received a number of months previously and we saw one complaint that had been received more than 10 months before the inspection had not been resolved. This meant that when concerns or complaints were raised they had not been investigated and responded to appropriately to reduce the risk of reoccurrence.

The above paragraph demonstrates a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked people using the service and visitors about the activities that were organised at the home we received mixed comments. People told us "I like to be able to get out, but I cannot go out on my own. They could do with more people to take us out….All they seem to do is watch TV; there's nothing else here", "There are lots of activities. I don't participate as they don't interest me" and "We go for a walk around outside if there is someone to take us." Other people said "Living here is quite good actually. There's always somewhere you can go. I like to sit and watch what's going on. I sit here; there's not a lot else to do actually", "The main thing is the television; we all like TV" and "Sometimes they go places, but I am too old [to want to go with them]…. I went to spend a day at my [relative's] house recently." A care worker told us "It can get boring and lonely here. They need more activities."

During the inspection we saw that activities were organised but some of them were not meaningful for the people using the service. We also saw when some activities were being held which involved a small number of people there were no alternatives for everyone else as care workers were busy. An activity coordinator worked at the home and there were notice boards on both units displaying the activities that were scheduled for each day. The activities included going for a walk, a quiz and exercise session. On a weekend the options were visits from family and friends on a Saturday with hymns on a Sunday morning and watching a film in the afternoon. This meant that people who did not have visitors or wished to attend a religious service had no other options for activities.

On one day of the inspection the activities coordinator supported 12 people to attend a lunch club however while they were out there were no other activities organised. Care workers had put on the television in one lounge and a film in the other but there was limited interaction between the care workers and people in the lounges as the staff were busy. We also saw the activity coordinator was only able to support three people to go out for a walk at a time which limited people's access to this activity.

We spoke with the activity coordinator who explained they identified activities that people liked and tried to have a mix of music, singing, puzzles and exercise activities each week. They confirmed that they had not received any formal training in relation to organising activities in a care home setting. The activity coordinator told us "There is not enough staff available to be able to get them to do activities when I am already doing something as they are busy." People could also visit an on-site hairdresser once a week and during the inspection we saw they cut men's and women's hair and people were encouraged and supported to make an appointment.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to them using the service. We saw detailed assessments were carried out before a person moved into the home to identify if the appropriate care and support could be provided.

These assessments reviewed their individual support needs including mobility, social and health issues and were kept in the person's care folder. This information was used in the development of the care plans.

People and their relatives were able to provide their feedback on the care provided. The interim manager told us a questionnaire had been sent to people using the service and relatives during March 2016. We saw the questionnaire that was completed by people living at the home used pictures and clearly written questions to help people provide feedback. The questions included if they felt they were treated with dignity and respect, their religious beliefs were respected and if they felt safe. We saw the majority of people who responded stated they were happy. The relatives of people using the service were asked for feedback on their contact with the service, administration, staff, activities and if they had any comments or suggestions about the care provided. We saw the majority of relatives stated the service met their expectations.

Inadequate

Is the service well-led?

Our findings

Records relating to care and people did not provide an accurate, complete and contemporaneous record for each person using the service.

During the inspection we asked the interim manager for the current dependency needs assessments of people using the service. These assessments identified how much support each person required and how many care workers were required to provide the appropriate level of care. The interim manager was unable to provide the current information as these assessments had not been recently reviewed. This information was provided after the inspection. This meant that the information used to ensure the service provided the appropriate level of support required by people did not give their current dependency levels.

We saw one person had a care plan in relation to medicines being administered covertly (which means without the person being aware they are taking medicines). We saw this care plan had not been updated when the person was prescribed a new medicine. We looked at the care plan for another person where medicines had been prescribed to be used for the exacerbation of the person's condition. We saw the notes from a healthcare professional referred to the care plan related to this person's medical condition but this was not in the folder.

We looked at the care plan folder for one person and saw the initial assessment did not include information about a specific medical condition which was referred to in paperwork provided by the person's relatives. The care plan and dietary requirements did not refer to this medical condition and any specific requirements in relation to this person's care. The interim manager explained that since the person had come to the home they had contacted the GP and appropriate medicines had been identified and prescribed for the person but this was not reflected in the care plans.

We saw that when care workers reviewed some of the care plans each month, instead of identifying if there were any changes in the persons' support needs or health, they wrote a description of the care that should be provided. This did not indicate if the person's care needs had changed during the previous month.

We looked at another person's folder and saw their mental health care plan which stated an assessment should be carried out for DoLS but there was no record of this having been carried out.

During the inspection we looked at the records maintained for six people in relation to their personal care and the records we saw had not been completed clearly and some days had been left blank. This meant that there was no record of what personal care had been provided. Care workers had to complete a record sheet recording if the person they were supporting had a shower, body wash, nail care, mouth care or their hair washed. For example, we saw the records of one person indicated they had not received any support with personal care on three days during March and 11 days during April. The records for another person showed 12 days had not been completed in March and four days were left blank in April.

We also looked at the fluid record charts which were completed by care workers to monitor the person's

fluid intake if they had been identified as at risk of dehydration. Each person had an optimum level of fluid intake recorded on their form and each day the completed form should have been checked by a nurse to see if the person's fluid intake was appropriate and take the required action if it was not. Some of the charts we looked at did not show the total fluid intake for the person each day. These forms had not been checked by a nurse and where the person had not reached their optimum fluid level action had not been taken.

We saw the repositioning record for one person who was immobile which should have been completed by the care workers every two hours during the day and every three hours at night. The records for one day indicated that care workers had not recorded that repositioning of the person had occurred between 18.30 pm and 8.30 am the following morning. This meant that the provider could not show that the person was repositioned during the night as indicated in their care plan. Therefore they were at risk of developing pressure areas as the provider could not monitor whether they were receiving care which protected them from developing skin damage.

The records for the application of prescribed topical creams were not always completed to show that the creams were applied in line with the person's prescription. We looked at the records for six people and we saw that care workers had not regularly recorded when a cream had been applied or if the cream was not required. We saw the records for one person who had been prescribed a cream to be applied two to three times a day and the record had not been completed for 16 days during April 2016. The records for another person stated their cream should be applied twice a day and we saw from the records that the cream had not been applied for 15 days during April 2016.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we requested a copy of the current training, supervision and appraisal records for all staff employed at the home. The interim manager initially provided a copy of spreadsheets containing this information but it was identified that the information was out of date. During the inspection the home administrator reviewed the files of all the staff to provide the current information in relation to the training and support of staff. This meant that the provider could not ensure that staff providing care had received the appropriate training and support.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's quality monitoring systems were not effective in identifying issues. Regular audits had not been carried out since the previous inspection to monitor the quality of the care provided.

The daily home manager's audit was not regularly carried out by the registered manager. The audit included checks on fire equipment, cleanliness, if cleaning materials were stored safely and if staff were working safely. We saw from between November 2015 and the end of February 2016 only five weekly audits were completed. We saw that actions were recorded on some of the daily audits but it had not been noted if these actions had been completed.

Meetings which were planned to take place each day, which the provider called, ''Take Ten'' meetings had not been regularly held by the registered manager. These meetings were held with senior staff to discuss any issues relating to staffing, maintenance, housekeeping or to each specific unit. Between November 2015 and the end of February 2016 only four daily meetings had taken place. We saw from the notes of these meetings that issues had been identified but there was no record that any related actions had been

completed.

There were two types of medicines audit that the provider had in place. There was a weekly audit that should have been carried out in each unit and a more comprehensive audit for each unit each month. We saw that in January 2016 only 2 weekly audits had been completed and these were signed by senior staff. During February three monthly audits were completed but only one weekly audit which was not signed as being checked by senior staff.

The infection control audit was completed monthly but we saw that where an action was identified there were no records of who should complete the action and by when.

We saw the food hygiene audit was completed for November 2015 had not been signed. Checks on the dining experience were also carried out and we saw the checks in November 2015 did not indicate which unit they referred to and notes on the observations that were carried out. The check carried out in December 2015 had identified action in relation to issues noted in the audit but there was no record that these had been completed.

An analysis had been carried out of the complaints received each month but we saw this had not been carried out since February 2016.

We looked at one person's care plan folder and saw a care plan audit form had been completed in February 2016. The audit contained a number of actions that had been identified where information was missing or changes to the care plan were required. We saw the audit did not indicate if these actions had been completed and the required changes made.

The provider had not identified, managed and mitigated risks to people. During the inspection we identified a range of issues including the recruitment process, storage of chemicals, training and support of staff and infection control. These had not been identified by the provider using their existing processes.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The number of audits had increased since the interim manager arrived and they confirmed a new range of audits were being introduced during May 2016.

Throughout the inspection the interim manager and other senior managers from the provider were open and helpful when we asked for information. They readily admitted they were aware of issues in relation to the quality of the service provided and were starting to take steps to make improvements. From the high number of breaches we have identified from the inspection it was clear there was a lack of oversight of the registered manager by the provider to ensure the processes in place to provide a good quality of care were being followed.

We asked people what they thought about the home and people told us "It's a nice place. They treat you well" and "On the whole the staff here are quite good." A relative told us "The carers are kind, chatty and cheerful. Every single one is hard working and lovely, kind, respectful, jolly, always lovely, every single one of them. They are the strength of the home. In January and February many good carers left; possibly due to the previous manager. Even within the last week I can see an improvement. I've seen at least ten new faces today. The only reason I did not move my relative was a nurse and the interim manager". Another relative said "It has improved recently" and "The quality of the care can be variable as there is quite a lot of turnover

of staff. My family member is reasonably well looked after but there has been instability of the homes management since they moved in."

The service had a registered manager in place but at the time of the inspection the registered manager was on extended leave. An interim manager had been in place at the home for four weeks. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

We received positive comments in relation to the interim manager from members of staff including "She has been great. She is direct about how she wants the place to run. She is approachable and lets you know how she feels about things" and "She has been quite supportive. When I came she said "Anything you want, just let me know".

We asked care workers if they felt they received enough support from their manager. They told us "Yes, we do have enough support. If I have difficulties, I talk to the nurse or the Unit Manager. Whenever there is a problem, we get it sorted" and "When I started it was a bit difficult because we were just changing managers then. The interim manager said if I need anything I should let them know. When she is back from leave we will meet to go through things. I hope I will get support then. I will know what to ask her when we meet". We saw the interim manager had organised regular team meetings were notes were taken and circulated to staff.

We asked care workers and nurses if they felt the home was well led. We received the following comments "The interim manager is currently managing the home – they are very good". "Since the interim manager has taken over, our work has got better and better. They sort out everything. Everybody is co-ordinated. The Unit Manager discusses things with the interim manager. The nurses and carers sit together and try to sort out the problems. Problems always get solved. This is the right approach. Everybody is asked to contribute", "I only work here three days a week so I can't really comment – I work opposite the Unit Manager. All of the team do contribute to make it an excellent home" and "Yes, it is well-led. Staff are organised well and know their roles and carry them out as they are supposed to do."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure people were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not ensure that any complaint received was investigated and necessary and proportionate action taken. Regulation 16 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9

The enforcement action we took:

The registered provider must submit to the Care Quality Commission a written report each month indicating the number of service users at Drayton Village Care Centre whose care plans have been updated during the previous month and provide confirmation that the service users or persons acting lawfully on their behalf were involved in the preparation and review of their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1)

The enforcement action we took:

The registered provider must submit to the Care Quality Commission a written report each month indicating the number of service users at Drayton Village Care Centre whose care plans have been updated during the previous month and provide confirmation that the service users or persons acting lawfully on their behalf were involved in the preparation and review of their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not have a system in place to assess, monitor and improve quality and safety. Regulation 17 (2) (a) The registered person did not have a process in place to assess the specific risks to health and

	safety. Regulation 17 (2) (b) The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record, including of care and treatment and decisions made. Regulation 17 (2) (c)

The enforcement action we took:

The registered provider must submit to the Care Quality Commission a written report each month indicating which audits at Drayton Village Care Centre have been undertaken during the previous month, confirmation as to whether all actions identified have been completed and also send a written report each month stating the action taken or to be taken as a result of the audits undertaken during that month in respect of incidents and accidents, complaints, activities, care plan audit and recruitment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

The enforcement action we took:

The registered provider must send the Care Quality Commission a written report each month which states the action taken or to be taken as a result of the audits which have been undertaken at Drayton Village Care Centre during the previous month in respect of incidents and accidents, complaints, activities, care plan audit and recruitment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

The enforcement action we took:

The registered provider must submit to the Care Quality Commission a written report in relation to Drayton Village Care Centre each month confirming: (a) Details of training, including induction training, completed

by staff during the previous month and (b) How many staff supervision sessions and staff appraisals have been carried out during the previous month.