Birmingham Jewish Community Care

Andrew Cohen House

Inspection report

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Ratings

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

Overall summary

The inspection took place over three days on 10, 11 and 16 February 2015. The inspection was unannounced.

We previously inspected Andrew Cohen House in July 2014. We found the provider had breached the Health and Social Care Act 2008 in relation to the care and welfare of people, safeguarding people from abuse, management of medicines, staffing, supporting workers and assessing and monitoring the quality of the service. Following that inspection the registered manager sent us an action plan informing us of the action they would take to address the breaches we found. We carried out a further inspection in September 2014 to check improvements had been made regarding management of medicines. We found that improvements had been made but that the provider was still in breach of the regulation.

Prior to our inspection we were made aware that the local authority and the local clinical commissioning group had concerns about the care provided. The local authority had stopped further placements at the home until the provider had made improvements to ensure people receive the appropriate care, support and treatment. At this inspection in February 2015 we found

Summary of findings

continued breaches of the Health and Social Care Act 2008 and multiple examples of how the registered provider was failing to meet the needs of the people it was supporting.

Andrew Cohen House is registered to provide nursing care and support for up to 59 older people who have needs relating to their old age, dementia or on-going health needs. When we visited, there were 46 people living at the home, 23 of them were receiving nursing care.

A registered manager was in post but they had been absent for a number of weeks due to illness. 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. In the registered manager's absence the home was being managed by the deputy manager, who was supported by a team of external consultants.

People told us they felt safe living at the home. All staff knew to report any allegation or suspicion of abuse.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. Whilst staff had identified some potential deprivations to people's liberty and had already made appropriate applications we found that, where people lacked capacity to make their own decisions, consent had not always been obtained in line with the law.

We saw that appropriate pre-employment checks had been carried out for new members of staff. to ensure as far as possible that only people with the appropriate skills, experience and character were employed in the home.

Previously the provider had not made suitable arrangements to protect people against the risks associated with unsafe use and management of medicines. At this inspection we found that sufficient improvements had been made and judged that this regulation was met.

Most interactions between staff and people using the service were kind and caring. However we observed occasions where staff did not demonstrate respect when providing support.

Care was not always assessed, planned or delivered to be responsive to people's needs. Staff were not always able to demonstrate good knowledge of people's needs. People had access to healthcare professionals such as GP's, dentists and chiropodists. However, some people's health and nutritional needs had not been met effectively. People and staff had mixed views as to whether or not there were enough staff to meet people's needs. Improvement was needed to the availability of staff to meet people's needs.

Shortfalls with staff training and support were identified and staff did not always have the skills and knowledge to meet people's individual needs effectively.

The provider was not adequately monitoring the quality of the service and therefore not effectively checking the care and welfare of people using the service. In addition to this the provider had sometimes failed to notify the Care Quality Commission of events in the home that they are required to by law.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not consistently safe.

Peoples needs were not always met in a timely manner and the deployment of staff had not ensured they were always available to meet people's individual needs.

Some aspects medicines management needed improvement.

All staff knew to report any allegation or suspicion of abuse.

Is the service effective?

Inadequate

The service was not effective.

Potential health concerns were not always acted on which resulted in some people's healthcare needs not being met. People could not be certain they would receive the support they required to eat a nutritious meal suited to their needs.

Not all staff had received training in topics that were relevant to the needs of people using the service. Staff were not effectively supported or supervised and were not always able to recognise poor practice.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most individual staff demonstrated kindness and compassion but the operation of the home did not ensure that people consistently received the care they needed.

Staff respected people's privacy but we observed occasions where staff did not demonstrate respect when providing support.

The running of the service did not always ensure that people were as involved in their care as they wished or were able to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively. Activities of interest to people who used the service were organised and people chose what they wanted to do.

People felt able to raise concerns and complaints but records did not show that all aspects of people's complaints had been investigated.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was no clear leadership to ensure the effective running of the home and this meant that people did not always receive the care and support they needed.

The systems in place to check on the quality and safety of the service were not effective. Some of the regulations had not been met and the provider had not ensured that people were benefitting from a service that met their needs.

Andrew Cohen House

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.

The inspection took place over three days on 10, 11 and 16 February 2015. The inspection was unannounced.

The inspection team comprised of three inspectors who visited at different times over the three days and a pharmacy inspector. A specialist advisor and an expert by experience also took part in the inspection. The specialist advisor had experience and expertise in nursing care with older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection. We also spoke with commissioners (the people who purchase this service).

During the inspection we spoke with eleven people who were using the service and six relatives. We used the Short Observational Tool for Inspection (SOFI) which helps us to understand what living in the care home might feel like for people who would find it hard to verbally tell us this. We also spoke with four health care professionals during the inspection and with the GP following our inspection.

We spoke with 17 members of staff including the deputy manager, care staff, nurses, activity workers, domestic staff, catering staff and administrative staff. We also spoke with the Chair of Trustees and with the team of consultants who had recently been contracted by the provider to help make improvements at the home.

We looked at the way medicines were being administered and managed for ten people. We looked at eight people's care records and records about health and safety, staffing and the records to show how quality and safety were being monitored.

Requires Improvement

Is the service safe?

Our findings

People confirmed that they did feel safe living in the home. One person told us, "I feel more secure here than in my own flat" another person told us, **"**I am fully protected here." Relatives we spoke with did not raise any concerns about people's safety. One relative told us, "[Persons' name] are safe and well, I've never seen any concerns about abuse."

At our inspection in July 2014 we found that there was no information on display to people about where they could report allegations of abuse and that the induction for new staff did not include sufficient information about safeguarding. At this inspection there were areas in the home where information on reporting concerns about abuse was available to people. An induction booklet for new staff had also been implemented that gave an introduction to safeguarding people from abuse. Staff were aware of what constitutes abuse and the signs that may indicate that a person had been abused. All staff knew to report any allegation or suspicion of abuse. One member of staff told us, "I've never needed to do it but wouldn't hesitate to do it."

Previously the provider had not ensured that incidents of a safeguard nature were being reported to the local authority as required. We found that improvement had taken place and that recent incidents had been reported as required. There had been a recent incident where a member of staff had raised concerns about the practice of another member of staff. This had been reported to the local authority and the provider had taken action to protect people. At the time of our inspection there were some safeguarding incidents that were still under investigation by the local authority.

At our inspection in July 2014 we found that people were not being protected from the risk of falls from full length opening glazed doors on the first floor. At this inspection we found that restrictors had been fitted to these doors and that checks were completed to make sure they were in good order. We were informed that there had been a recent incident where some people's call bells had not worked. Discussion with two members of staff and a relative indicated that prompt action had been taken to address the issue and ensure that the risk to people from them not being able to call for assistance had been reduced. Investigation of a recent concern by one of the team of consultants had identified that staff were able to cancel the call bell at the panels in the hallways rather than in the person's bedroom. This meant that there was the potential that if someone needed urgent assistance there may be a delay in staff providing this. We were informed that it was intended to contact an engineer to make sure the system was adjusted so that call bells could only be turned off in the person's bedroom.

We viewed a sample of maintenance and servicing records, and these were up to date. Weekly fire alarm and extinguishing equipment checks had been recorded and monthly checks had been done for emergency lighting, bedrails and window restrictors to ensure they were in good working order.

The systems to manage risks to people needed improvement. One person had recently experienced two falls. Whilst medical treatment had been sought for the person their risk assessment and care plan had not been updated following either fall. This was a risk as staff may not know how to reduce the risk of the person falling. We asked a member of staff about the people who were at risk of falls, they did not name this person. No analysis of accident records had been completed to identify if there were any patterns or trends so that learning could take place and action taken to reduce risk. We observed staff assisting people to move or transfer using equipment and saw they did this safely. One person told us that due to their mobility they needed to be hoisted and that this was always done by two staff to protect them from harm.

Our inspection in July 2014 found the provider had not made suitable arrangements to ensure there were enough staff on duty to meet people's needs. Numbers of nursing staff on duty at night were below the numbers we were informed should be on duty by the provider. At this inspection we found the numbers of nurses on duty at night had been increased.

We did not see people having to wait significant lengths of time to receive support from staff but we noted that in the mornings staff were very busy and call bells were frequently ringing out and not immediately answered. Lounge and dining areas were not left unattended by staff when being used by people. Since our last inspection an assessment of people's needs had been carried out and used to inform staffing levels.

Many people told us it would be nice to have more staff so that they had more time to spend with them. One person

Requires Improvement

Is the service safe?

told us, **"**Staff give time when they can, but they are very pushed and have a lot to do." Another person told us there was always a delay in responding to requests for support, and some staff members came and switched off the buzzer and left without assisting them. Some relatives held concerns about staffing levels, one commented, "I think there are adequate staff on [duty], it's rare there is an issue." Other relatives told us that there had been issues with staffing that were improving whilst some relatives had concerns about the availability of staff. Comments from relatives included "Staffing is better, there's only the odd occasion when people have to wait." "There has been a vast turnover of staff and at times no care staff on the floor but this has improved over recent weeks". "I can see today there are many staff around here and they seem very active, but once they feed people the staff will disappear."

Staff had mixed views as to whether or not there were enough staff to enable them to perform their roles effectively. Some staff reported they could be rushed and did not have enough time to spend talking with people whilst others told us that staffing levels had improved. One staff told us, "Staffing levels are good but that is because the numbers of people at the home are currently reduced. We now have more time to look after people." Health care professionals did not raise any concerns with us about the numbers of staff on duty during our inspection but two raised concerns about the deployment of staff. One health care professional told us "I've no concerns about staffing numbers, it's just sometimes difficult to find them.

New staff we spoke with confirmed that the necessary checks including references and a Disclosure and Barring Service check had been made. We looked at the recruitment records of two recent staff starter and saw that all the required checks had been made before the person was offered a position within the home. These processes helped to reduce the risk of unsuitable staff being employed to work at the home.

Previously the provider had not made suitable arrangements to protect people against the risks associated with unsafe use and management of medicines. At this inspection we found that sufficient improvements had been made and this regulation was met although we continued to find some errors. We were shown checks that were being made to ensure that medicine records were accurate and that people had been given their medicines. We noted that on one morning of the inspection the administration of some of their medicines for two people had not been signed for and no reason documented to explain why they had not been given. Nursing staff we spoke with explained that the medicines had been given however they had forgotten to sign the medicine record chart. One person's medicine chart had been handwritten which had been checked and signed as accurate by two members of staff. However, it was not dated and it was not possible to know which date, month or year the medicine chart related to. This meant that it would not be possible to determine when the person had been given their medicines. Another person's medicine chart had confusing directions for the administration of a strong pain killer, which had not been clarified or discussed with the person's doctor, this failed to ensure that the directions for staff to give the person the medicine were clear would be and easy to understand.

When people were given a medicine prescribed as 'when necessary or when required' the reason the medicine was given was not documented. In particular we looked at three people prescribed a medicine to be given when required for agitation. There was no supporting information available to enable staff to make a decision as to when to give the medicine for agitation. We had identified this at our previous inspection. No action had been taken, however a team of consultants in the service had identified immediate action would be taken to ensure that appropriate documentation would be available to support staff.

Inadequate

Is the service effective?

Our findings

We spoke with several members of staff who had started working at the home in the past seven months. All but one of them told us they had completed an induction that included working alongside more experienced staff. One member of staff told us, "My induction was okay, what I got was good." Since our inspection in July 2014 the provider had introduced a new induction booklet for staff that took into account the Skills for Care Common Induction Standards (CIS).

We asked staff if they received regular supervision. The majority of staff told us they received supervision but that it was not always regular. One member of staff who had worked at the home for several years told us they had only received one individual supervision session, another staff was unable to recall when their last one had taken place. One member of staff told us "We don't have supervision sessions, I've been here since June and I've never had one. We have team meetings though." The team of consultants working in the home had identified that individual supervision was needed for some staff, and had commenced this process.

We asked staff about the training they had received. Some staff were complimentary about the training they had received. One member of staff told us, "I've had lots of training since I started working here." Other staff told us there were gaps in their training or that the quality of the training needed to be improved. One member of staff told us, "I never get my training, I always get called out, they do training but I'm called out, I can't remember when I last had safeguarding." We asked staff about the specialist knowledge they had to meet the specific needs of people living in the home. We found that many staff had gained experience over their years working in care, but some staff had not been given suitable training in areas such as dementia, diabetes, nutrition and hydration or the Mental Capacity Act. It was common practice in the home for domestic staff to assist people with their meals at breakfast. We were not provided with evidence to show that these staff had completed all the training they needed to undertake this role.

Failing to provide staff with the training, induction and support they need to undertake their work is a breach of the Health and Social Care Act 2008.(Regulated Activities) Regulation 23. During our inspection we were shown evidence that the consultants working in the home had identified that improvement was needed to the training arrangements. They had liaised with a training provider and a further meeting was scheduled to develop an effective training plan.

Some people who used the service were living with dementia and lacked capacity to make certain decisions for themselves. Staff knowledge about the Mental Capacity Act and the impact it had on their work was limited, but we saw evidence that training to address this was being scheduled. Records and discussions with staff identified that some people were being deprived of their liberty and the provider was able to demonstrate that this had already been identified and that applications had been made to the local authority regarding these deprivations.

One person's records indicated that they required their medicines to be hidden in their food or drinks as they might not take them. Some staff told us medication was sometimes hidden but other staff told us it did not need to be hidden. Whilst signed permission was in place from the GP there was no evidence that this had been agreed to be in the person's best interest, or that guidance had been sought on which medication could be hidden and the best food and drink to hide the medicines in. There had been no mental capacity assessment completed to determine if this person was able to be involved in this specific decision.

We found that there were a number of 'do not attempt resuscitation' (DNAR) forms in place. A DNAR tells staff and members of the emergency medical team that the person should not be resuscitated if they stopped breathing. In some instances we did not see evidence of suitable best interest discussions to show that the decision made was in the person's best interest, where people did not have capacity to consent. One person had a DNAR in place, the reason for this decision was recorded that the person had dementia. For some people the GP had signed the form many months after its initial completion and so the information may not have been up to date. One person had a DNAR form in place but records showed a more recent form had been completed. Staff could not locate this during our inspection. The team of consultants working in the home had identified that review of DNAR decisions was needed and were in the early stages of completing this.

One person had a number of care plans in place that indicated staff could undertake minimal restraint and hold the persons's hands when they became distressed during

personal care so that the care could be carried out. Whilst the plan recorded that the holding must not exceed a given time there was no information to record the specifics of when this should be used and what staff should do if the person did not want their hand to be held. We were not shown evidence to show these actions had been agreed in the person's best interests. Some staff we spoke with told us the person's hands did not need to be held provided you approached them in the right manner but one member of staff told us they had to hold this person's hands every time they undertook any personal care. These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2010.

We undertook observation of breakfast and lunch time meals in both of the dining rooms. We observed some good practice from staff and for most people the meal was pleasurable and people seemed to enjoy their meals and were allowed time to eat at their own pace. People were offered a choice of food and drink and staff respected their wishes. For some people, their experience at meal times was not a pleasant one. During the course of one meal we saw the staff support for one person changed frequently as staff got up and left the person to help someone else or to undertake another task. Some people were assisted to the table by staff but waited a long time for their meal. One person sat waiting with no support for 50 minutes.

People's risk of malnutrition and dehydration was not always effectively responded to. Despite written guidelines in people's care plans or guidelines developed by a dietician the majority of staff we spoke with were not fully aware of people's nutritional needs. We asked staff about one person who required their food to be fortified. Care staff we spoke with were not aware of this and only one of the two catering staff we spoke with were aware of this need. One of the catering staff told us that there no one at the home needed a fortified diet. One person was assessed as requiring a daily yogurt. Staff were not aware of this. One member of staff told us they had never seen this person with a yogurt.

We saw that one person had not eaten all of their breakfast and a member of staff took their breakfast bowl away. Their food chart was later completed to record they had eaten all of their breakfast. This meant that the food record gave an inaccurate account of what the person had eaten, placing the person at risk of inaccurate assessment of the support needed.

A relative told us that sometimes when they visited the person did not have access to water in their bedroom. A health care professional told us that at a recent visit people did not have access to drinks in the lounge. We saw that fluid monitoring charts for people did not show they were having enough to drink. We asked staff how much people needed to drink to stay healthy. Most of the care staff we spoke with were unable to tell us. We informed a care staff that one person's care plan said they should have 1400 mls daily. They told us, "They're not getting that."

We asked staff about the needs of a person who had diabetes. Their care plan recorded they should be offered sweetener instead of sugar. A senior carer told us, "[Person's name] is on a normal diet, they are not diabetic. They have normal sugar food and eats chocolates, I didn't know they were diabetic." Another member of staff told us, "We know not to give [person's name] sugar, but sometimes they get aggressive if they don't have sugar. No we haven't used sweeteners instead." We received some positive comments from people about the meals on offer but the majority of people had negative comments. One person told us, "The food is very bland here."

We had received information prior to our inspection that indicated people may be a risk of not receiving the health care they needed. During our visit we spoke with care and nursing staff about people's needs and looked at people's care records. People's care records were often confusing and did not always show people had the care they needed. Many of the staff we spoke with were unable to tell us about people's specific health care needs when we asked them.

During our inspection a nurse from the clinical commissioning group (CCG) told us they had previously asked staff to arrange for a dietician referral for one person as they had lost weight. They told us this had not been done. Records confirmed this. We spoke with the GP who told us that there were some signs of improvement in the home but that they felt staff did not always refer people to them as quickly as they should when people were unwell.

There was a failure to meet some of the needs of people using the service. We asked staff about the care of one person who needed to wear protective equipment because they had sore skin. Many of the staff we spoke with were unclear about when this needed to be worn. The care records for this person showed that a health professional had visited twice and had to ask for the person to wear

Inadequate

Is the service effective?

their protection as it was not being worn. One person's behaviour chart had numerous entries of them wanting to use the toilet. Whilst the person was assisted on each occasion there was no evidence that any consideration given to other possible reasons for them feeling that they needed to urinate, for example an underlying UTI or other health problems or changes. One person was at risk of constipation. Their care records and handover records had recorded they had not had their bowels opened for over eight days. A nurse was unable to tell us if any action had been taken to address this concern. We eventually tracked through the records and found this person had recently been to the toilet but there was no assessment to show if they remained constipated or not. We looked at the care plans for two people, neither plan directed staff as to the action to take if the person was constipated.

People were not protected against the risks of receiving unsafe care because the provider had not comprehensively assessed, planned and delivered, or reviewed the care provided to ensure people's welfare and safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The majority of people told us that they received good health care. People who lived at this home and their relatives agreed that they had regular GP's visit and also visits from the chiropodist and optician. One relative told us, "The home is quick to get medical help." Another relative told us, "[Person's name] was poorly the other day, staff acted really quickly and they are fully recovered."

Requires Improvement

Is the service caring?

Our findings

The majority of people told us that staff were kind to them. Comments from people included, 'I think they are very kind and supportive", 'Some staff are better than others, but some of them are learning so can't be put at fault" and "Staff are very pleasant and helpful." One person told us, "The staff came and woke me up, but they didn't come back for a very long time. They made me feel a positive nuisance. Sometimes at night they leave the light on full. It's not a nice way to wake up."

Relatives we spoke with mainly described the staff in very positive terms. One relative told us, "I think it's very good, there have been problems, but things have gotten significantly better over the last few weeks. The individual carers are very good, they exhibit a great deal of humanity. The staff are very kind and considerate."

Family and friends were able to visit when they wished. One relative told us, "The staff here make the effort to know you by name, and this makes us comfortable and it makes us feel as though we are at home." Another relative told us, "I can visit any time." This enabled people to maintain contact with people important to them.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service. We used this because some people were unable to tell us in detail what it was like to live at the home. We saw many examples of staff speaking to people in a kind manner. Staff communicated with people effectively and used different ways of enhancing that communication by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately. On one occasion we observed a person becoming upset and a member of staff reassured the person and comforted them.

We also saw some practice that was not caring or considerate. One member of staff attempted to put a clothes protector on a person whilst they were asleep. The person awoke with a startled expression to find the staff completing this task without first seeking their permission. The same person was later relaxing in their chair when another member of staff wheeled their chair into a different position without informing them first. This caused the person to look anxious as staff had not explained what they were doing.

We saw that people were given green or red plastic mugs when they had a hot drink, whilst visitors to the home were given cups and saucers. This did not promote people's dignity. We were told that some people needed plastic mugs as other types were too heavy for people. The approach of everyone being given plastic mugs may not meet individual preferences. Consideration had not been given to maintaining dignity of people by obtaining plastic mugs that were similar in appearance to crockery given to visitor's to use.

People had been supported with their personal care and were seen to be wearing well fitted and clean clothing. One relative told us, "[Person's name] is always well groomed. They do her hair and makeup, it's attention to detail, it's the little things that make a difference."

The people we spoke with said that staff respected their privacy and dignity. We asked care staff what they did to protect people's dignity and privacy and all the staff we spoke with were able to

describe how they did this. We saw examples of this including staff knocking on people's bedroom doors and seeking permission to enter and doors to people's bedroom and bathrooms were kept closed when people were being supported with their personal care needs. Some people who were at risk of having their dignity compromised when staff assisted them to move with the hoist were well supported. During these manoeuvres staff used privacy screens to protect people's dignity.

CCTV was in use in communal areas of the home, and notices were on display informing people of this. Since our last inspection people and their relatives had the opportunity at a meeting to discuss its use in the home. People and the relatives we spoke with did not raise any objections to its use but many were unsure what areas of the home were covered by the CCTV.

The home aims to meet the religious and cultural needs of people of the Jewish faith through its observance of the Sabbath, festivals and the provision of strictly kosher food but also provides care to people of other faiths. We found that the care records for one person who followed another faith recorded their religion but there was no information

Requires Improvement

Is the service caring?

about how their religious needs were met. The staff we spoke with did not know what the person's religion was. This meant it was unlikely that this person's religious needs were being met.

Arrangements to enable people to express their views or to be involved in making decisions about their care needed to be improved. People we spoke with were not sure if they had been involved in their care plans. One person told us "I don't like to attend any meetings because they won't listen to you, they only do what they want to do." A relative told us, "This is a good home but they need to listen to relatives. They do talk and consult with us but they could do better at involving us in the care."

Requires Improvement

Is the service responsive?

Our findings

One health care professional told us that whilst some staff knew people's needs well other members of staff did not. They told us they were making frequent visits to the home to audit people's care records and to identify where improvements were needed. They told us that whilst some actions had been taken to address issues they had identified this was not consistent. Some issues they had identified regarding individual care plans had not yet been rectified.

People had care plans in place but information was held in several different folders and was not always detailed about their specific needs. Where reviews of people's care had been completed it was difficult to establish what information had been used to inform the review and who had been involved. Care records had usually been reviewed monthly, however we did not see evidence of people being involved in these reviews, so their opinions were not being sought with regard to any changes in their needs or wishes.

Staff we spoke with were often not aware of people's needs. During our inspection we spoke with the staff on duty about people's needs. We found that for most people we asked about we received conflicting information from staff or staff told us they did not know about those particular needs. This meant people could not be confident that staff had the knowledge they needed to meet their individuals care needs.

There was a lack of detail in the care plans which meant staff were not given sufficient information to ensure they met people's needs effectively. We found that some people's care plans had not been reviewed following significant events, such as experiencing a fall which is important as their needs may have significantly changed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people we spoke with who lived at the home were happy by the care provided by the staff and did not feel they had to be involved in their care planning and reviews. One person told us, "I don't know anything about my care plan, my family must be aware." The care files that we looked at often did not show how people had been involved or consulted about their care.

Some people at the home were living with dementia. We noticed on the first two days of our inspection that a large clock displayed incorrect information in respect of the year which people may have found confusing. The inspection visit took place in February it was likely that the clock had been displaying the incorrect date for several weeks. This had been rectified by the third day of our visit. People were not adequately supported to orientate themselves around the home. Corridors and handrails were painted in similar colours. Some toilets had pictorial signs to help people identify the room's purpose. However, there was little signage to help people find their way around the home or identify their bedrooms.

We looked at the opportunities people had to undertake interesting activities each day. The majority of people we spoke with were happy with the activities that were on offer. One person told us, "There's always something going on." The home employed two activity co-ordinators. We found that people were given the opportunity to participate in a number of activities and organised events at the care home. One of the activity workers told us that activities were often personalised such as painting, puzzles, flower arranging, nail painting, exercise and short day trips rather than group activities and that they created activities depending on individual's wishes and preferences. During our inspection we saw people engaged in one to one activities and also enjoying a visiting entertainer. Information was available to people about the activities on offer and each month there was a planned day trip.

We observed visitors being made welcome at the home throughout our inspection. We saw that relatives were enabled and supported to provide care where they wished or for example to help a person with their meal or drink. This would help people not to feel isolated and maintain links with people that were important to them.

None of the people we spoke with had made a complaint about their care but they told us if they had a problem they would speak to a senior care worker or the manager. One person told us they had raised some concerns regarding the food but that action was not taken in response to this. We received some mixed responses from relatives in regards to how concerns or complaints had been dealt with. One relative told us, "The deputy has taken action when I have raised things. I would definitely be confident in raising a complaint if needed." Another relative told us they had been told they raised too many complaints and this

Requires Improvement

Is the service responsive?

had put them off making further complaints. People and their relatives had been made aware of how to make a complaint at meetings and we observed information about how to complain and raise concerns was on display around the home. On a weekly basis a member of staff spoke with each person at the home to check if they had any complaints to raise.

Since our last inspection the provider had introduced additional systems to help people or their relatives make a complaint, to include a dedicated complaint telephone number and e-mail address. In recent weeks, the consultants working in the home had introduced new comments and suggestions box. One member of staff told us, "The relatives here complain all the time. They are good at it." This comment did not assure us that this member of staff would take people's concerns or complaints seriously.

We looked at the action taken to deal with two recently recorded complaints. We found the system to record complaints was disorganised and the individual records did not show that all aspects of people's complaints had been investigated. Records were also unclear showing which aspects of people's complaints had been upheld. We noted that for both of the recent complaints, an apology had been issued.

Inadequate

Is the service well-led?

Our findings

We had previously inspected this home in July and September 2014. Breaches of the Health and Social Care 2010 were identified at both visits. Despite an action plan being developed the provider had failed to remedy all of the breaches from our inspection activity. This inspection did not find that the leadership, management and governance of the home had been effective.

We were concerned that the governance arrangements put in place by the registered provider had failed to identify the number, complexity and severity of the issues we identified during this inspection. The checks and audits in place to monitor the safety and quality of the service were inadequate. We found that records of checks and audits showed these had not been undertaken in the detail or with the frequency required to obtain a true picture of the experience of people living at the home.

During our inspection we identified a number of issues in relation to people's nutrition, hydration and health care needs. One relative told us, "Meal times need sorting out and the management need to sit in there to see what is going on." We asked the deputy manager if any audits had been completed in these areas to check the quality of care people were receiving. We were informed that audits had not been completed due to a lack of auditing tools to complete this. The last available audit of the home's infection control procedures had been completed in June 2014. Staff were unable to locate any more recent audits and did not know if any had been completed.

Following our last inspection, the provider sent us an action plan about how they would monitor the medication practice in the home. Part of the action plan was to complete medication competency assessments for staff. The staff we spoke with were unsure if these had been completed. We had previously identified that satisfactory guidelines for the use of 'as required' medication was needed to make sure people received this medication appropriately. This inspection found the guidelines in place were not detailed. We found that there was not a system in place to analyse the number and type of accidents and incidents occurring in the home. We were shown the incident file, this contained a record of just one incident occurring. The system in place did not enable the provider to complete a full analysis in order to identify any reoccurring patterns or trends. This meant the provider had not taken full account of our previous inspection reports. A member of staff told us, "Incident reports are something we have not done in the past, the consultants have just introduced these and I have now attended a workshop on this."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. The registered manager or the provider had not always informed us of significant events that they were required to. This showed that they not fully aware of their responsibility to notify us and we could check that appropriate action had been taken.

During our inspection a concern was raised with us that a person at the home needed a nursing procedure carried out and it had not been done. We discussed this with the person in charge. They confirmed this had not been completed and said this was because the staff on duty were not trained to do this and that all of the equipment needed was not available. We emphasised our concern to the person in charge and asked what alternative arrangements they would make to ensure the person's needs would be met. We were informed by the person in charge the procedure would be done the following day. Due to our level of concern we brought this issue to the attention of one of the consultants working in the home. They were able to establish that the procedure had been done the previous day. We were concerned that the person in charge had not been aware of this and had also not taken any action to rectify the issue when we brought this to their attention. This showed a lack of effective leadership and lack of understanding of the potential risk to the person.

These issues were a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. This states that the registered person must protect people against the risks of inappropriate or unsafe care by means of effective systems to regularly identify, assess, monitor and manage risks relating to the health, welfare and safety of people.

A registered manager was in post but they had been absent for a number of weeks due to illness. In the registered manager's absence the home was being managed by the deputy manager. During our inspection we were informed that the deputy manager had secured alternative employment and was due to leave. They were no longer working at the home on the third day of our inspection.

Inadequate

Is the service well-led?

We spoke with people and relatives about the management arrangements and leadership in the home. One person told us "This home is not as good as it used to be three years ago. Last year a few good staff left, this is a sign, of what things are like." Another person told us they did not know who the manager was as the management changes frequently. Several relatives told us the home was not very well organised. One relative told us, "I visit regularly and noticed staff don't have good communication amongst them. There is a great need for improvement." Another relative told us, "It needs a lot of improvement. It has gone down in the last year mainly due to management, nursing and staff changes. The manager is not strong and not leading." One relative told us the home was improving. "I'm aware of the recent changes, it wasn't run very well under the last manager, no one seemed to know who was doing what. It's much better now, it's really turning around."

Some relatives and staff told us they were confident in approaching the manager with any concerns but not everyone felt confident. One relative told us, "It's a huge improvement since the deputy started. [Person's name] is the manager but I bypass her and speak to the deputy as [Persons' name] is not approachable. One member of staff told us, "I have always felt able to raise concerns with the manager but not with the previous director of the home. I feel able to raise anything now, the organisation is prepared to put the money in to improve things."

Staff were being supported by a team of external consultants who had been employed by the provider to help make improvements. Many of the staff we spoke with were unclear on the role of the consultants and who was currently in charge of the home. At the time of our inspection the consultants had only been in post for a few weeks and had insufficient time to address all of the issues or the culture of the home. They had already identified some of the issues we found during this inspection and were able to show us some of the systems they were implementing and tell us about their plans to make improvements. Both the Chair of the Trustees for the registered provider and the consultants showed a commitment to improving the service for people at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users or another person able lawfully to consent on their behalf. They did not establish or act in the best interests of service users in line with the MCA 2005.** Regulation 18 (1) (a) and (b) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People using the service did not benefit from a staff team that had been trained and supported to undertake their role.**

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People could not be certain they would receive the care and treatment they required.

The enforcement action we took:
We issued a warning notice to be met by 30 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not take proper steps to protect people from the risks of unsafe or inappropriate care. They did not have an effective system to identify, assess and manage risks relating to people's health, welfare and safety.

The enforcement action we took:
We issued a warning notice to be met by 30 April 2015.