A Walsh

The Warren Residential Lodge

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection of this home on 30 June and 1 July 2015. The Warren Residential Lodge provides accommodation and personal care for up to 31 older people. The home is arranged over one level with access to all areas. At the time of our inspection 26 people lived at the home.

The registered provider of this service was an individual provider and therefore was not required to appoint a manager. They had appointed a nominated individual to manage this service on their behalf. This person was not a registered person for the service and as such did not have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The legal responsibility for this service was with the registered provider.

Summary of findings

People said they felt safe at the home. Relatives had no concerns about the safety of people; however this was in contrast to our findings at this inspection.

Staff and in particular managers did not have a good understanding of the local guidelines, policies and procedures in place to safeguard people from abuse and avoidable harm. Reporting and follow up of such incidents was poor.

People who lived with specific health conditions had not had the risks associated with these conditions assessed and plans of care were not developed from these to ensure their safety and welfare.

Whilst there was sufficient staff on duty at the time of our inspection, there were not adequate systems in place to ensure there was always enough staff in place to meet the needs of people and to monitor the changing needs of people who lived at the home.

Medicines were stored safely, however appropriate practices, policies and procedures were not in place to ensure people received their medicines safely and effectively.

People were not always supported by staff who had the necessary skills and knowledge to meet their needs. Whilst training records showed some staff had received training to meet people's needs, this was not consistent

People consented to the care they received. The requirements of the Mental Capacity Act 2005 (MCA) were followed. Managers had a good understanding of the requirements of Deprivation of Liberty Safeguards (DoLS) although they had not needed to make any applications for these.

People had access to external health and social care professionals as they were required, however information provided from these professionals to the service was not always followed up and adhered to.

People received support to ensure they had sufficient food to eat and drink.

People said staff were caring and supportive. Staff knew people at the home well. However, whilst most people had discussed their plans of care with staff, they did not always receive full information to make decisions about their care needs.

Care plans for people lacked clarity, were incomplete and were not always specific to people's needs. We were not assured they reflected people's wishes.

The investigation and review of complaints, incidents, accidents and serious events which occurred within the service was ineffective and did not support learning within the home. Incidents and accidents were not investigated, recorded and reported in line with the requirements of the law. Learning was not identified and acted upon to ensure the safety and welfare of people.

Some systems were in place to allow people the opportunity to feedback about the care and treatment they received.

Whilst people knew who the management team of the home were and felt they could approach them, the management team did not have clearly identified roles which supported each other and the needs of people at the home. The registered provider and their nominated individual were not a visible presence in the home. There was a lack of clear structure and support for staff in the home.

A lack of robust audits in the home meant concerns we had identified had not been observed by the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that the service is therefore in special measures.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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?
The service was not safe.

There was a poor understanding in the staff team of local guidelines, policies and procedures in place to safeguard people from abuse and avoidable harm.

Identified health risks to people had not been assessed and were not monitored to ensure people were safe

There were inadequate systems in place to ensure there were always enough staff in place to meet the needs of people.

Medicines were stored and disposed of safely. However, appropriate policies and procedures were not in place to ensure people received their medicines safely and effectively.

Inadequate

Is the service effective?
The service was not effective.

People were not always supported by staff who had the necessary skills and knowledge to meet their needs.

People consented to the care they received. The requirements of the Mental Capacity Act 2005 (MCA) were followed. Managers had a good understanding of the requirements of Deprivation of Liberty Safeguards (DoLS) although had not needed to make any applications for these.

Whilst people had regular access to external health and social care professionals as they were required, information provided from these professionals was not always followed up and adhered to.

People received support to ensure they had sufficient food to eat and drink.

Inadequate

Is the service caring?
The service was not always caring.

Whilst people had discussed their plans of care with staff, they did not always have the opportunity to be involved in making informed decisions about the planning of their care as care plans did not recognise and fully inform their care needs.

People, relatives and professionals said staff had a caring attitude.

Staff knew people well and were compassionate and respectful.

Requires improvement

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

Care plans for people lacked clarity, were incomplete and were not always specific to people's needs. We were not assured they reflected people's wishes.

The investigation and review of complaints made to the service was ineffective and did not support learning.

Some systems were in place to allow people the opportunity to feedback about the care and treatment they received.

Is the service well-led?

Inadequate

The service was not well led.

The management team at the service did not have clearly identified roles which supported each other and the needs of people. The registered provider and their nominated individual were not a visible presence in the home.

A lack of robust audits in the service meant concerns we had identified had not been picked up and dealt with.

Incidents and accidents were not investigated, recorded and reported in line with the requirements of the law. Learning was not identified and acted upon to ensure the safety and welfare of people.

The Warren Residential Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 30 June and 1 July 2015 following concerns which had been raised with CQC by members of the public. The inspection team consisted of one inspector and an expert by experience in the care of 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with eight people who lived at the home and four visiting relatives to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home. We spoke with nine members of staff, including the home manager, two deputy managers, two heads of care, care staff and kitchen staff. We spoke with one health and social care professional. The registered provider met with us at the end of our inspection.

We looked at the care plans and associated records for eight people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, three staff recruitment files and policies and procedures.

Following our visit we spoke with two more health and social care professionals who supported some of the people who lived at The Warren Residential Lodge.

The previous inspection of the service was completed in March 2014 when no concerns were identified.

Inadequate

Is the service safe?

Our findings

People felt safe at the home. One person told us, “I feel safe as they always check me at night.” People told us they knew staff very well and could always talk to them if they were concerned about anything. Relatives said they felt their loved ones were safe and that staff knew them very well. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

People were not protected by staff who had a good understanding of when to raise safeguarding concerns and how these should be investigated and reviewed to ensure people’s safety. When we spoke with three managers at the home there was confusion as to what a safeguarding incident was and when a concern should be identified to the local authority for further investigation. These managers told us they had received conflicting information from different health and social care professionals as well as CQC and other organisations about what they should and shouldn’t report as safeguarding concerns to the local authority; when they did report alerts to the local authority they told us they did not always receive any feedback of the outcome of their alert. They did not seek feedback on these alerts or document any concerns they may have about them. A copy of the local authority "Safeguarding Adults Policy 2013 Multi-agency Policy, Procedures and Guidelines” was available for staff and this informed the provider’s own policy on safeguarding of people. However the service managers did not have a good understanding of this.

Two incidents which had occurred at the home within the three months before our inspection were under review by the local authority as serious safeguarding concerns. The investigations completed by a manager of the home into these incidents to inform the safeguarding alerts lacked detailed information.

The home held no logs or records of safeguarding concerns which had been raised in relation to the care provided at the home, or any concerns which had been identified to the managers and investigated. We were aware the service had supported two people with significant mental health care needs who had subsequently moved from the home. A manager of the home told us of incidents which had occurred with these people which were reported under safeguarding to the local authority. We were aware the local authority had been involved in the management of the care for these people. However, there were no records of the safeguarding incidents which had occurred with these people being reported to the relevant authorities, no evidence of the actions a manager had taken to ensure the safety of others or any learning they had identified from these alerts. During our inspection we identified two significant concerns relating to the safety of people at the service and raised these alerts with the local authority for further investigation. The managers had not recognised these concerns.

Of 23 members of care staff working at the home, 17 had not received training on the safeguarding of people. For 13 of these care staff training was planned to be completed at the time of our visit although there was no date stipulated for this completion. Two members of care staff we spoke with had a good awareness of the types of abuse they might see and told us they had received training on how to identify and report any form of abuse. They told us they would report any concerns to a manager. They told us if they did not feel they could report it to a manager they would find out how to report their concerns to an outside organisation such as CQC or the local authority.

People were not protected from abuse and avoidable harm by staff who had a good understanding of the policies and procedures available to them to keep people safe. Safeguarding concerns had not been appropriately shared, investigated, recorded or recognised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not in place to ensure the safety of people. For people who lived with a long term health condition there were no risk assessments in place to identify the risks associated with their condition and how these could be reduced to ensure the safety of the person. This meant staff did not have access to information on how they could support people and reduce the risks associated with their care.

For one person who had a breathing condition there was no information in their care records of the risks this presented to them or how these could be reduced. For three people who lived with diabetes a risk assessment document in their care records, specifically to identify the risks associated with this condition, had not been completed. For two people who had catheters in place to support their continence needs there were no risk

assessments in place to identify the needs associated with this equipment. For another person who took medicines to thin their blood there was no information in place in their care records in relation to the nature of the risks associated with their treatment. For people who were at risk of falls, assessments in place lacked clear information on the steps staff should take to mitigate any risks.

When we spoke with staff about these risks they were not aware of many of the conditions we had identified. For example, staff were not aware of the blood clotting disorder for one person. We asked two members of care staff if they were aware of any significant risks for this person in relation to their health conditions should they fall or injure themselves and they were not. One member of staff told us they were aware of the people who lived with diabetes but not how they needed to adapt the person's care to meet this need and the risks associated with it, such as poor circulation and risk of infections.

We spoke with the managers for the service and asked why the specific risks associated with health conditions had not been identified in people's care records. They told us they were not medically trained and relied on the GP and other health care professionals to guide them on this. They had not recognised the need for risk assessments and the subsequent need for guidance for staff in relation to these needs.

The lack of understanding of the need to assess the risks for individual people in relation to their specific needs put people at risk of receiving unsafe treatment or care and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst medicines were stored and disposed of safely, people did not always receive their medicines as they were prescribed. They were not supported to take these safely and in line with their individual needs. A manager told us they were in the process of updating their medicines policy at the time of our inspection and this may have led to some confusion about the current policy for the administration of medicines. Staff we spoke with were not aware a new policy was being implemented and told us the policy for use was in the staff room.

We observed the administration of controlled medicines on two occasions and noted there was a lack of consistency in the way in which this was done. Staff were unclear on the policy for the administration of these medicines and this meant we could not be assured these medicines were given safely and in line with the relevant professional guidance available. We observed four controlled medicines for four different people being dispensed into separate pots and then stored on the medicines trolley. All of these medicines were signed for as they were removed from the controlled medicines cupboard. The medicines were then distributed to people and signed for by a second person to say they had been witnessed as administered. When we asked a member of staff why all four medicines had been dispensed together as there was a risk they could get muddled, they told us, "It's okay, as I know who each one is for." We reported this unsafe incident to a manager who told us they would address this.

We looked at 26 medicines administration records (MAR) and identified medicines prescribed on a regular basis were administered as prescribed. There were no gaps in these records and regular audits of medicines were completed. Care records held a consent form for administration of medication by trained staff for people who lived at the home. However care plans were not in place to identify the management of medicines for people and how they should be supported to take these or any risks associated with these. Homely remedies authorisation forms were held in all care records but had not been completed and staff told us they were not used. Homely remedies are medicines which can be bought over the counter at a pharmacy to support people in the management of minor ailments such as headache and constipation. We spoke with the managers about the use of the forms which were available within care records. They had not considered the use of these authorisation forms which may have supported a more improved method of administering medicines for these needs when people only required this very occasionally.

Medicines to be given as required (PRN) were not managed in accordance with people's individual needs to manage symptoms such as pain, heart symptoms and maintaining good bowel habits. There were no protocols in place for these medicines to show when the medicines may be required, what they were for or the effect the medicines had when they had been administered. We saw people were not asked routinely if they required the medicines nor were records kept of the effectiveness of them when they were administered.

Inadequate

Is the service safe?

For one person who was prescribed a strong painkilling drug PRN, we observed that staff administered this medicine three times per day for the person without asking whether it was required or assessing their need for this. They had no pain assessment record in place and staff did not monitor the levels of pain for this person. When we asked the person how their pain was they told us, "It's bearable". Staff did not monitor or review the effectiveness of this person's medicines.

Some people who lived at the home were prescribed aperient medicines PRN to help them to maintain a good bowel habit. Staff did not ask, or record they had asked, people whether they required this and there were no records kept to identify when this may be needed. When these medicines were administered, staff did not record if this had been effective or further treatment was required. Staff told us they did not ask people about their bowel habits as, "It is a sensitive subject and not everyone wants to talk about it." This meant staff were not assessing the need for and administering medicines as they had been prescribed and in line with people's needs.

For people who required topical creams to assist with pain management or moisturising of their skin, prescriptions lacked detail on where the creams should be applied and at what times. Care records lacked information on how and when these creams should be applied and how to monitor the effectiveness of them.

Medicines were not managed in a way which ensured people received them in a safe and effective manner with regard for the risks associated with them. This was a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff on duty at the time of our inspection to meet the needs of people. However the managers told us it was difficult to ensure adequate staffing levels were maintained if staff were absent from their shift and could not be replaced. They said some people who lived at the home had required a lot more support and supervision recently to manage their needs and expectations and this had had an impact on required staffing levels. We asked the managers how they ensured there were sufficient staff on duty at any one time to meet the needs of people. We discussed two recent significant events where high demands had been made on staff to accommodate the needs and expectations of two people who lived at the home. We also discussed an increased number of incidents of falls and other incidents where people had been injured and these incidents had been unwitnessed. They told us they had a set number of staff and worked to this. They did not assess the dependency of people and the associated levels of staff required to deal with this. The managers acknowledged that in recent months the increased needs of some people who had lived at the home had had an impact on the time and efficiency of the service. They had not used any method of dependency monitoring or evaluating to consider the necessary staffing levels for the home.

The lack of monitoring and review of appropriate staffing levels to meet the needs of people, together with increased patterns of unwitnessed incidents meant we could not be assured sufficient staffing levels were in place when needs changed and was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment records for staff included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

People had a personal emergency evacuation plan in place (PEEP) which was kept in their records for use by staff and emergency services. An Emergency Fire Plan Pack was situated at the entrance to the home clearly identifying actions to be taken in the event of an emergency.

Inadequate

Is the service effective?

Our findings

Staff knew people well and people were happy with the care they received. People said staff helped them to be as independent as they could be and would help when it was required. One person said, "They help me with anything I ask but I like to do things myself." Families said staff met the needs of their relatives. One person said they felt she was very supported to be as independent as possible and they were very happy with staff attitudes. Two health and social care professionals told us staff worked well with them and called them as they were needed. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

People were not always supported by people who had the necessary skills and knowledge to meet their needs. We were told staff had received training to complete an invasive clinical procedure and support two service users who had catheters in place. There were no records available to identify which staff had received this training, their level of competence with this procedure or the monitoring or reviewing of this skill to ensure people's safety. We spoke with three managers about this and they told us they had not thought of the need to ensure staff were competent or confident to complete this task as, "The community nurses taught the staff to do it." This skill requires regular practice to ensure competence and confidence is maintained and appropriate techniques are used to ensure the safety and welfare of people.

Staff training records were being updated at the time of our inspection. There were significant gaps in these records. For example, we saw 14 of 23 members of care staff were currently working at the home without training in moving people. Training was noted as planned but no date was supplied. A further 20 members of 23 care staff had not accessed training on health and safety, which was required every three years according to the provider's policy. A manager told us these records were being reviewed and staff were being put onto courses as soon as possible but that this work had been delayed as the manager had been absent from the workplace and this work had not been completed.

The registered provider had made a commitment to staff to support any who wished to attend further training in external qualifications such as National Vocational Qualifications (NVQs). These are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

At an inspection of this home in November 2013 a manager was implementing a new structure of supervision and appraisal. This had not been completed at this inspection visit, although a manager told us they were working hard to implement it fully. There was a lack of opportunities for staff to have one to one discussions in a confidential way with managers about any concerns they may have regarding their work, any training needs they may have identified or any support they required in the workplace. Supervision sessions had not been completed for all staff. Records showed 16 members of care staff had received one supervision meeting with a manager since January 2015. The providers policy dated January 2012 did not state how frequently these sessions should be available for staff although, "All staff will be given a personal development file in which they should build upon." These files were being collated at the time of our inspection; however this work had been started at our previous inspection in November 2013 and was still incomplete.

Supervision sessions which had been held provided a training opportunity for staff, supervision of their practice and often were related to a concern raised about their practice or an identified learning opportunity. We discussed this with the manager responsible for the roll out of these supervisions. They acknowledged supervision sessions were taking time to be established and they were working on a new policy for the structure and management of these to ensure they provided a supportive and confidential opportunity for staff to develop skills and also have their voices heard.

Staff told us they felt able to speak with some managers about any concerns they may have however there was no formal structure for this reporting. A whistleblowing policy was in place and staff were aware of this. One member of staff told us, "It could be difficult to talk to managers as they are family." They told us they were aware of the whistleblowing policy but were unclear on who they could discuss any concerns with if they related to the managers of the home. Staff did not have a clear understanding of who their line manager was and who they were accountable to.

Inadequate

Is the service effective?

We saw some working relationships between managers, staff and the provider could present challenges in the management of the service due to personal relationships. We discussed this with the managers of the service. They told us they recognised it may be difficult to report concerns to or about people who they were close to and this was to be reviewed and discussed as a management team. Personal relationships within the staffing structure meant we were not assured staff would always seek and receive support and advice they required in a timely and supportive way.

The lack of appropriate training, clear structure of staffing and support for staff to allow them to carry out their roles effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had regular access to external health and social care professionals as they were required. Records showed people had access to a variety of specialist services including podiatry, specialist nurses, community nurses, GP and audiology (hearing). However information provided from these professionals to the service was not always followed up and adhered to.

For one person who had visited hospital recently, a GP had fed back to the service the need for monitoring of this person's bowel movements as they had suffered a gastric bleed whilst in hospital. This had been documented in their care records. There was no evidence in care records, or in discussion with staff, that this had been acknowledged or followed up. For another person we saw they had a wound dressing to their arm. Staff told us community nurses were visiting regularly to dress the wound and monitor this. There was no information in this person's care records to suggest this person was being visited by the nurses for any reason, there were no support plans in place for staff to follow should they have any concerns about the wound. For a third person a message in their care record following a GP consultation dated 23 April 2015 stated staff should continue to give a medication as required, "as this is more flexible to manage pain- contact GP to report any further concerns to the GP." Staff had not been administering this medicine flexibly for over two months and when we asked staff if they had followed this up with the GP they told us they had not. This meant people were at risk of not receiving care and treatment in line with their recognised needs from healthcare professionals.

People were not always supported to maintain good health through appropriate support from other health care professionals as their guidance was not always followed or actioned. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed all people who lived at the home had capacity to consent to their care and treatment. Staff sought their consent before care or treatment was offered and encouraged people to remain independent. People were encouraged to take their time to make a decision and staff supported people patiently whilst they decided. The manager we spoke with had a good understanding of the principles of the Mental Capacity Act 2005 and when these would need to be applied to ensure any decisions were made in a person's best interests. Care records held clear information which showed people had consented to the care which had been discussed and agreed with them. Records showed only seven of 23 members of care staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) since 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect the person from harm. The service had acknowledged their awareness of these with the local authority but had not needed to make any applications at the time of our inspection.

People received a variety of homemade meals which were provided on a four week rolling rota of menus. The chef spoke with people about their preferences and asked for feedback from people when they met with them day to day in the home. Care plans in place lacked detail on specific preferences for people and special diets such as those required for people who lived with diabetes were not always recorded. The chef told us they were aware of people who required a diabetic diet. People told us there was minimal choice of meal available at lunchtime as a set menu was prepared, however they could have something else if they asked for it such as jacket potatoes or "anything else the cook can provide." One person told us they never had fresh vegetables and the cook confirmed the time taken to prepare these meant they tended to use frozen vegetables which were, "just as good". There was a warm

Inadequate

Is the service effective?

and friendly environment in the dining room for people to enjoy their meal and the interaction between staff and people was minimal but supportive. People who chose to eat in their room were supported to do so. At the time of our visit the weather was extremely hot and staff ensured sufficient fluids were available for people to reduce the risk of dehydration. The kitchen area was clean and well managed with foods and utensils stored appropriately.

Requires improvement

Is the service caring?

Our findings

People felt they were well cared for at the home. We observed that staff were kind, respectful and understood their needs. One person told us, "They are very kind girls, very understanding and considerate, they take time to talk to you and understand you. You can talk to any of them…." Another said, "I've never been so happy. I can't fault it." Relatives were very happy with the caring and supportive approach of staff to looking after their loved ones. One relative said, "We have just seen such a difference in her, she is so happy." A health and social care professional said care staff were very kind and supported people in a respectful way.

Whilst people had discussed their plans of care with staff, they did not always have the opportunity to be involved in making decisions about and planning of their care as care plans did not recognise and fully inform their care needs. Staff had not always identified to people risks associated with their care as they had not been recognised. People were not always given the information to make informed decisions about their care, support and treatment.

Relatives told us they spoke with staff regularly to update their loved one's care needs and could speak to staff at any time if they had a concern care needs had changed. Whilst daily records showed staff spoke with people regularly to ensure their needs were met, this was not always reflected in their care plans.

Staff were respectful and compassionate with people and had a good understanding of the need to ensure they respected people's privacy and dignity.

People felt happy to express their wishes to staff and these were respected. Staff encouraged people to be independent in their daily routines, and respected their wishes. For example, one person had decided they did not wish to sit in the lounge, but would rather sit in their room watching a sports programme on television. We saw staff supported this choice and regularly checked on them. Staff responded to people's calls quickly and efficiently.

Inadequate

Is the service responsive?

Our findings

People felt able to raise any concerns they may have about the service with staff or the registered manager. They said staff were approachable and responded to requests or concerns in a prompt and efficient manner. Relatives felt staff were approachable and responsive to any issues they may raise. Health and social care professionals said staff reacted to the needs of people and called them whenever they were required. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

People were at risk of not receiving the care and treatment they required as their needs had not been identified in sufficient detail. Each person had an individual file of care records. On admission to the home, information had been sought from people and their families to gather a history of their life and personal preferences. This information then helped to inform a 'Person Centred Care Plan' which managers told us was to help staff identify how they should support the person. These contained brief information on activities such as using the toilet, eating and drinking, washing and dressing and mobilising. Whilst these care plans were personalised, they were very basic. They identified generic tasks for staff to support people with, such as, 'requires supervision when mobilising' and lacked clear information and instruction for staff on how to meet the individual needs of people. Each person's care file held a record called, 'Ambulance Anticipatory Care Plan (AACP)' These documents were all very clearly marked with people's previous medical history, medicines and contact details and were used when any person was admitted to hospital from the home. These documents were clear and concise however, the information they contained was not reflected in people's care plans and risk assessments.

For one person who had a catheter in place to support with their continence needs their care plan for using the toilet identified the person required no assistance with these needs. However staff told us they supported the person with the management of their catheter. There was no mention of the catheter in any care plans or how this should be managed.

For people who lived with specific health conditions such as heart conditions, breathing difficulties, blood clotting disorders and kidney problems, care plans held no information on how these impacted on a person or how staff should assist them to manage these. For two people who lived with long term kidney problems, care plans held no information on how they should be supported to have adequate fluid intake to maintain their optimum health. For another person who was at risk of bleeding should they fall or injure themselves care plans held no information on how staff should monitor this condition

People who lived with diabetes were not provided with consistent support to manage their health condition and care plans were not completed in an individualised way to reflect the needs of people. For one person, who required the administration of insulin to manage their diabetes, care plans lacked guidance specific to the person as to how staff should monitor and support the person should they become unwell. A specific care plan for diabetes was in their records but was incomplete, undated and the information within it did not inform other records of care for the person. For a second person who lived with diabetes their care plan for eating and drinking stated they were independent with eating and drinking and did not have any problems or needs. It said staff should supply the person with appropriate food and drink throughout the day. There was no information to identify a special diet was required or should be offered for this person with respect to their diabetes

People who required support to manage pain did not have any information within their records to ensure staff monitored and addressed this need. There were no tools available for staff to support people in identifying how their pain impacted on their wellbeing and how they could be supported to manage this. For two people who lived with persistent pain due to their medical condition and required strong pain medicine to support this, we saw staff did not evaluate and monitor this effectively. Their care records held no information on how staff should support them with this need. People were at risk of not receiving the care and treatment they required as staff had not identified this need.

People were not supported to monitor and manage their continence needs such as bowel movements and urine output. Care records did not reflect the need for staff to discuss this need with people and support them to address any issues they may have such as constipation or infection. Some people who were at risk of falls and required support to manage this did not have care plans in place to identify

Is the service responsive?

this need. Care plans lacked detail on how staff should support people to reduce this risk. This meant people were at risk of not receiving the care and treatment they required as staff had not identified this need.

The lack of consistent and effective plans of care in place to meet the individual needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

During our visit we observed people independently participating in activities such as reading, general conversation with others, sitting in the garden in the sunshine and enjoying each other's company. There were no planned activities as the exceptional hot weather at the time of our inspection meant people did not wish to participate in organised activities so they had not been arranged on this occasion. We saw a range of activities were available and readily advertised for people including; a church service, exercise, hairdressing, crafts, games and quizzes. People told us they were happy to join in with activities as they occurred and two people told us they regularly went out either independently or with family members. Care records did not reflect activities people participated in, however people were independently able to access activities as they wished.

Few people knew about their care plan or what was in it; some were aware of reviews of their care. People did not always know if their care plans reflected their wishes although people told us they were happy they received the care they needed. This meant whilst the provider had sought the views of people, they could not always be assured care plans were a true reflection of people's wishes.

Daily records were maintained by staff to record the activities people had participated in during a day and the support and care they had received. Information from the daily records was not always used to update care plans. Daily records lacked detail, were often incomplete and were not collated in a way which effectively supported plans of care or information on the needs of people on a day to day basis.

A manager told us they encouraged people and their relatives to provide feedback about the care and support they received. A survey of people's views was collated from December 2014 and showed people were generally happy with the service. People told us there had been meetings in the past which they could attend to discuss the care at the home, however they were not regular and they did not know when they had last had one of these. The managers could not recall the most recent meeting of people who lived at the home or their relatives and could not provide us with any notes or minutes of meetings with people. They told us they regularly spoke with people to ensure they were happy with the service and were confident people would approach a manager if they were not happy with the service being provided.

Many compliments about staff and the service they provided had been received from people and their relatives and these were held in files at the entrance to the home. People said they were happy to raise any concerns they had with staff or the managers of the home and felt sure their concerns would be dealt with. The provider had a complaints process in place which was clearly available for people. A manager told us they had received no formal written complaints since our last inspection, however we were aware some verbal complaints had been received to and about the service and that the service was aware of them but they did not appear in the service's complaint records. There was no system in place to record, monitor, investigate, evaluate and learn from complaints or concerns which had been raised in the service unless they were formal written complaints. Although the service had not received a formal written complaint recently, the service held no log of concerns or issues which had been raised by people or their families to show how these had been managed and informed learning in the service.

The lack of systems in place to monitor and effectively manage complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us they knew who the managers of the home were and got on well with them. They felt able to approach any manager and request support and were happy they would receive a prompt and effective response from them. Relatives were happy with the way in which the home was managed and told us they found all staff very approachable. One health and social care professional visiting the service told us staff knew people well and requested support from them when it was appropriate. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

The registered provider did not provide an active role in the home on a day to day basis. They had delegated this role to the home manager who was identified to CQC as the nominated individual for the home. Two deputy managers were employed at the home and one head of care alongside two senior carers who supported the role of head of care when they were absent. There was a lack of leadership and management in the home at the time of our visit. Whilst records showed managers had experience and qualifications of management, they were not clear on their specific roles in the home and often responded in a way which identified other managers to be responsible for management roles and functions which they did not identify was within their own remit.

One manager told us they dealt with all issues relating to employment of staff and human resources activities including training and recruitment. This manager told us this area had been neglected since our last inspection in March 2014 as they had been absent for some time and this had not been followed up. We were told by another manager they were responsible for the management and upkeep of care records and were supported in this by the head of care. This manager told us the concerns we had identified around the very poor audit, management and recording in care records was due to their lack of time and support to manage and implement a new system which had been purchased by the registered provider.

Managers in the service were not clear on their roles and responsibilities. Managers told us training, supervision and support for them was not always available. Some managers told us they may find it difficult to discuss or address concerns relating to the service with the registered provider and home manager as they were closely related. As a family run business there were potential conflicts of interest for staff that they had identified and told us about but which had not been clearly addressed. Close family members worked together to provide the service and also people who used the service were also related to members of staff. Within the service we were made aware of at least four people who were closely related and also people who lived at the home were related to staff and friends. Potential conflicts of interest that had not been assessed and feedback from staff themselves meant that we could not be assured that any issues or concerns would be raised and addressed in a transparent manner.

Staff told us the deputy managers and head of care were very visible in the home and felt able to approach them with most matters of concern. However two members of staff told us it may be difficult to approach a manager at times as 'they are family'. The home manager told us they promoted an open and honest working ethos and encouraged people to report their concerns to managers. They told us they recognised it could be difficult to address matters with family members and acknowledged this required review.

Managers within the service did not understand their responsibilities in reporting, investigating and recording of incidents, accidents complaints or concerns which occurred within the service. Incident records were completed by staff only sometimes when an incident occurred. There was no system in place to monitor records of incidents and accidents which occurred in the home, no investigations had been completed into incidents such as falls, injuries to staff and incidents of aggression between people and staff. Whilst managers could tell us these had happened, there was no evidence these had been investigated and any learning from these incidents shared across the service. There was no information to support the monitoring of these incidents for trends and recurrent themes which required further investigation.

Before our inspection we had identified to the local authority concerns about the increased number of falls and serious incidents at the home which had not been investigated or reviewed. The home managers were working with the local authority to review this. When we discussed this with managers we were told they had not recognised the need to complete reviews of incidents and had not received any training or guidance on the

Is the service well-led?

investigation of such events. Managers told us, "We get so much conflicting information and advice it is difficult to know who to listen to." This related to advice they had been given from health and social care professionals, CQC, the local authority and guidelines they had been signposted to.

We were told by a head of care of two incidents which occurred in the service over a single weekend which were serious and had not been documented, investigated or recorded. These included a serious incident of aggression by a person towards a member of staff which had been reported to the local authority.

The lack of understanding of the need to monitor and effectively manage incidents which occurred meant we could not be assured the registered provider had effective systems in place to ensure the safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required by law to notify CQC of important events which occur within the service. We were told during our inspection of some significant incidents of injury, harm and potential abuse which should have been reported to us which had not been. These included injury to staff, police incidents and incidents of aggression between people. Managers were unclear when they were required to inform CQC of such incidents and confirmed these had not been completed regularly.

The lack of recognition and reporting of these incidents to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Care records in place to support the management of people's needs were not always accurate, complete or held in an organised manner. Information relating to people's individual care was recorded and stored in a variety of places and did not provide consistent and effective information sharing for staff to support the needs of people. Daily records completed by staff did not inform care plans. A communication book in place was used to report and record a wide range of activity and actions taken by staff in support of people. However this information was not then used to inform care planning or daily records. Information and instruction provided by health and social care professionals did not always inform plans of care or instruction for staff on the management of people's needs. A lack of accurate and clear records meant staff did not always have up to date and clear guidance on how to meet the needs of people. People were at risk of not receiving the care and support they required to maintain their safety and welfare.

The lack of accurate, complete and clearly organised records was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to review the audits which had been completed at the home to measure if the service was safe and effective for people. These audits included; health and safety, medicines administration, care plans and environmental audits. We were told these were completed by the home manager and were not available at that time. We asked after our inspection for this information and did not receive this. The home manager told us these were being worked on.

Whilst the home may have had audits in place to monitor the safety and welfare of people, these had not identified the many concerns we had identified at our inspection in relation to care plans, medicines management, the safety and welfare of people, the availability of staff and the governance of the home.

Regular staff meetings were not organised at the time of our inspection but a manager told us these were to be planned. We reviewed the minutes of the last staff meeting which were dated 12 February 2015 attended by managers and front line staff. At this meeting a manager identified how the unprofessional behaviours of some staff was having an impact on staff morale and the standard of care being delivered to people. Directions were provided for staff informing them how the manager expected these matters to be dealt with. Further instructions for staff were noted from the meeting with regard to voicing their opinions, knocking doors before entering rooms including the manager's office, the home being messy and the need for staff to ensure they took breaks appropriately. There was no information in these notes to suggest staff were given the opportunity to raise any concerns they may have or any follow up information from these meetings. There was no action plan or follow up notes for this meeting put in place to address any actions required. This meant we could not be assured staff were receiving effective and supportive leadership to manage concerns they may have in the service. An appropriate support network was not always available for staff.

Inadequate

Is the service well-led?

The lack of effective governance and quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use the services had not had their care planned and delivered in line with their individual needs and to ensure their safety and welfare. Regulation 9 (1)(2)(3)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks were not identified for service users to inform plans of care. Incidents and accidents were not reviewed and analysed to ensure people's safety and identify learning for the service. People did not always receive their medicines in a safe and effective manner. People were not always supported to maintain good health and appropriate support from health care professionals. Regulation 12 (1)(2)(a)(b)(c)(g)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure people were always protected from abuse and avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Systems were not in place to monitor and effectively manage complaints to the service.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not in place to monitor and effectively manage the governance of the service. Regulation 17 (1)(2)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a lack of monitoring of safe and appropriate staffing levels. Staff did not receive appropriate training and support to carry out their roles effectively. Systems were not in place to monitor and effectively manage complaints to the service. Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider had failed to notify the Commission of incidents within the service.