G.S.G. Nursing Homes Limited

Craven Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The comprehensive inspection of Craven Park took place on the 8 and 10 January 2019. The first day of the inspection was unannounced.

Craven Park is a care home that provides nursing care and accommodation for a maximum of 26 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. During our visit there were 15 people using the service, including one person who was in hospital until the afternoon of the second day of the inspection.

People's bedrooms were located on three floors. There is a passenger lift to assist people to access their bedrooms located on the 1st and 2nd floors. People have access to safe outdoor space and the home is located close to shops and public transport.

The service does not have a registered manager. A registered manager is a person who has registered with the CQC 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. A manager had been in post since July 2018 but left the service in early January 2019. The service is currently being managed by the consultant operations manager with assistance from the deputy manager.

At the last inspection on 18 January and 2 February 2018, we rated the service Good overall but in the area of Well-Led, we rated the service Requires Improvement. This was because we found oversight of day to day delivery of the service was not always effective. We found shortfalls to do with the moving and handling of one person using the service and in the monitoring of two people's fluid monitoring records. During that inspection management had been responsive in quickly addressing the deficiencies that we found, but their quality monitoring systems had not been effective in identifying the issues that we found. We made a recommendation that the provider sought advice from a reputable source about the development of 'monitoring spot checks' of the service, to ensure that deficiencies were identified and addressed promptly.

During this inspection we again found shortfalls in the monitoring of people's drinking. We also found deficiencies in other areas of the service. People's medicines were not always managed in a safe way, and not every person using the service were provided with regular access to meaningful activities that met their preferences and protected them from social isolation. Care plans were not in place to meet some people's specific medical conditions. People's risk assessments lacked detailed guidance, staff recruitment checks were not robust, and records did not show that all staff members had completed an induction.

Audits and quality monitoring checks had been carried out and identified deficiencies in the service, but audit records did not show details of proposed action by the service to address the shortfalls and show that shortfalls had been addressed and improvements made. This indicated that the quality monitoring and

quality improvement systems of the service were not effective in mitigating all the risks to the health, safety and welfare of people using the service and possibly others including staff.

We found that there were five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Some areas of the interior surroundings had been improved, but there were parts of the premises and some furnishings, which remained tired looking. Also, some repairs had not been addressed.

There were some aspects of the service that were positive. People's relatives spoke of a welcoming atmosphere. We found that staff engaged with people in a caring and respectful manner and they understood the importance of treating people with dignity and protecting their privacy.

The service had clear procedures to support staff to recognise and respond to abuse and keep people safe. Staff knew how to identify abuse and understood the safeguarding procedures they needed to follow to protect people from harm.

People and their relatives provided us with some positive feedback about the service.

Further information is in the detailed findings below.

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 always safe.

People were not always protected by the proper and safe management of medicines.

There was not always detailed guidance for staff to follow to reduce and manage risks to people. People's monitoring records were incomplete, so people were at risk of harm.

Proper staff recruitment practices to ensure only suitable staff were employed by the service were not always followed.

Staff were knowledgeable about the procedures for safeguarding people using the service and others.

Is the service effective?

Requires Improvement

The service was not always effective.

Records did not show that all staff had completed a comprehensive and effective induction, and regular supervision and appraisal of their performance and development.

Staff had not received training/learning about a specific medical condition that several people lived with.

Staff supported people to access advice and treatment from a range of healthcare services.

The service understood the requirements of the Mental Capacity [MCA] Act and Deprivation of Liberty Safeguards [DoLS], which helped ensure people's rights were upheld.

The premises including the garden were accessible to each person using the service.

Is the service caring?

Good

The service was caring.

The atmosphere of the service was welcoming.

Staff were caring. People were treated with kindness and had their privacy respected. However, people's care plans included little detail about their background and life experiences to help staff more fully understand and meet each person's needs.

People's relationships with relatives and others important to them were supported by the service.

Is the service responsive?

Requires Improvement

There were areas of the service which were not responsive.

People's care plans and other records did not show that people's specific health and care needs were always understood and met by the service.

It was not evident that people had the opportunity to take part in a wide-range of activities that met their preferences, minimised the risk of social isolation and enhanced their well-being.

Information about people's background and preferences lacked detail to help staff understand people's individual needs and wishes concerning their care.

People's needs were assessed before they moved into the home. Records of monthly reviews of people's care needs lacked detail and did not show that people using the service, and when applicable their relatives had the opportunity to participate in reviews of their care.

There was a system in place to manage and respond to complaints effectively.

Is the service well-led?

Requires Improvement

There were areas of the service which were not well-led.

There were processes in place to monitor the quality of the service, but checks were irregular and lacked action plans to show that improvements to the service were made when shortfalls were found.

Records did not show that the service always provided staff with the support and direction that they needed to ensure people always received a safe and good quality service.

The deficiencies found during the inspection indicated that the management and leadership of the service were not effective in ensuring that people always received a good quality, safe service.

Craven Park

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 was prompted in part by information shared from local authorities about deficiencies that they had found during checks of the service.

This was a comprehensive inspection. It took place on 8 and 10 January 2019. The first day of the inspection was unannounced.

The inspection was carried out by a lead inspector with assistance from two other inspectors, a specialist nurse advisor and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information we held about the service, including statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by others, such as local authorities that commissioned care services for people from the provider.

Due to us changing the inspection date we did not ask the provider to complete a Provider Information Return [PIR] prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

To help gain information about people's experience of the service, we observed engagement between staff and people who used the service. We also observed interaction between staff and visitors.

During the inspection we spoke with the nominated individual (person employed by the provider who has the responsibility for supervising the management of the regulated activities). We also spoke with the consultant operations manager, deputy manager, three nurses, six care workers, two cooks, a laundry

assistant, six people using the service and six people's relatives.

We also reviewed a variety of records, which related to people's individual care and the running of the service. These records included care files of seven people using the service, eight staff records, audits and policies and procedures that related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Some risks to people's safety had been identified. These included risks of people falling, mobility risks, risks of developing pressure ulcers, choking and risks of using of bedrails. Whilst we saw that risk assessments had been carried out in these areas, the service had not always ensured there was detailed guidance for staff to follow to reduce the risk. For example, a person had been assessed as having a high risk of developing pressure ulcers, but there was no record of what action staff should take to manage and minimise the risk.

Also, a person had been assessed as being at moderate risk of choking, but guidance to reduce the risk to keep the person safe did not include advice from a healthcare professional. So, staff might not be aware that the person needed close supervision by staff when eating and drinking to minimise the risk of choking. We asked a care worker if they were aware of a person's 'safe swallowing plan', and they told us that they used their "common sense" because they knew the person well. This indicated that guidance about managing risks was not always fully communicated to staff, so people could be at risk of being harmed. We addressed our concerns with the consultant operations manager, who told us that action would be taken to ensure communication with staff about all aspects of people's needs staff would be improved.

Another person had a moving and handling assessment in place. However, the person's assessment and care plan also lacked detailed guidance for staff to follow to minimise the risk of the person being harmed. For example, the person's mobility care plan stated that staff should use "the right equipment" but did not include details about the type of equipment that needed to be used by staff to keep the person safe. We also found that a person's bed rail risk assessment had not been fully completed, so risks to the person's safety may not have been identified.

A person using the service had a care plan that provided staff with guidance on how to manage and monitor the person's feeding regime. The person's feeding regime guidance showed that they required 1060mls of fluid through their feeding system every day. However, the person's fluid monitoring record charts showed incomplete and possibly inaccurate records of the amount of fluid the person had received daily. This indicated that the objective of the person to receive 1060mls of fluid every day had not been met. Some of the person's 'daily' fluid monitoring record charts during December 2018 and January 2019 were 'blank' and contained no confirmation that the person had received fluids on those days. The deficiencies in this record keeping could mean that the person had not received the fluids they needed and be at risk of dehydration. Checks carried out by the service had not identified the shortfalls that we found. During the inspection a nurse addressed the issue and when we checked the records on the second day of the inspection that person's fluid monitoring records were complete.

Another person's fluid monitoring chart indicated that the person had not had a drink from 17.30 on 7 January 2019 to 05.32 on 8 January 2019. This person's and other people's fluid monitoring charts did not include records of the total amount of fluid each person should aim to consume each day to keep well and be safe. During the inspection a nurse gave a person nutritional supplements but did not record it on the fluid monitoring chart until we mentioned it. There were no records to indicate that staff had recognised the deficiencies in the recording of people's fluid intake and therefore people's possible risk of dehydration.

A person's care plan had not been updated to include advice from the person's doctor that they have their weight checked every two weeks in response to losing some weight. So, the person could be at risk of any further loss of weight not being identified by staff.

Information in people's care plan files and the guidance in people's care records located in their room sometimes differed. For example, a person's pressure ulcer had been regularly assessed by a tissue viability nurse (TVN) who provided at each visit up to date guidance about the care and treatment of the person's pressure ulcer. We noted that the most recent guidance from the TVN had not been transferred to the person's monitoring file located in their bedroom. This could lead to the possibility of the person not receiving the care and treatment that they needed and of being harmed.

People's wound care records did not always include up to date body maps and photographs to show that the progress or deterioration of wounds were monitored closely. A person had a device to promote wound-healing. Guidance detailed that 2 hourly checks of the device should be carried out. Records showed that these checks were carried out during the day but not during the night. There was also a gap in the records which indicated no checks were carried out from 4 January 2019 to 7 January 2019. This showed that guidance from a health professional was not always being carried out, which could put the person at risk of harm.

The service had a medicines policy. People we spoke with told us that they were satisfied with the support they received from staff with their medicines. There were suitable arrangements for storage, disposal and auditing of medicines. Procedures for the safe administration of controlled drugs (drugs that are subject to high levels of regulation) were being followed. We checked 10 people's medicines administration records (MARs). Nine MARs had no unexplained gaps, which indicated that those people had received the medicines that they were prescribed. However, from 31 December 2018 to 7 January 2019 one person's MAR had six gaps, which indicated that the person had not received a laxative medicine as prescribed. No other gaps in recording were noted in that person's MARs.

We also noted that the quantity of each medicine received into the home had not always been recorded to show that the service had received the correct amount of prescribed medicines from the pharmacist. Five out of the ten MAR charts examined did not have information that indicated that staff had counted the medicines when they had been received by the service. An accurate record of the medicines received by the service, and a record of the running total of the quantity of medicines helps to ensure that there is a correct record of the amount of medicines held by the service. These checks help to identify any missing tablets, any possible incorrect administration dosages of medicines, and where misuse of a medicine had occurred.

The service carried out daily medicines' audits. However, those checks had not been effective in identifying the shortfalls that we found. It also showed that the appropriate action had not been taken by the service to address the issue of people not always receiving their prescribed medicines despite a similar issue having occurred a few weeks before the inspection.

The above issues are a breach of Regulation 12 (2) (b) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records confirmed that nurses had up to date registration to practice. We looked at eight staff records. These included recruitment, induction, supervision and appraisal records. The staff records contained essential documentation that included criminal record checks, evidence of identity, and permission to work in the United Kingdom. However, seven staff records contained only one reference. This was not in line with the provider's policy of obtaining more than one reference before recruiting a member of staff and indicated

that recruitment procedures were not being operated effectively. More than one reference that includes a reference from a previous employer, provides a more robust check of the potential employee and minimises the risk of unsuitable staff being employed by the service.

The above issues are a breach of Regulation 19 (2) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure there were sufficient staff on duty so people received the care and support that they needed and were safe. Due to care staff recruitment the service employed less agency staff than they had during 2018. However, the consultant operations manager told us that due to there being two nurse vacancies there was still a need to employ agency nurses. They told us that they employed agency nurses who were familiar with the service so that there was continuity of nursing care. On the first day of the inspection an agency nurse who had worked in the home on other occasions was employed by the service.

We noted during the inspection that call bells were answered within about two minutes. However, some people told us that there were occasions when staff did not answer their call bell quickly. A person using the service told us, "Whenever I press the call bell they never come because they are too busy. So, I can't use the bell unnecessarily." The deputy manager told us that she checked how quickly calls were answered and if there was a significant delay, she would remind staff to ensure that call bells were answered promptly, but if care staff were busy she would answer the call bell herself. Regular checks of people having access to their call bell were carried out and care plans with guidance were in place when people due to their needs were unable to use a call bell.

The atmosphere was calm, and people were not rushed by staff. The consultant operations manager told us that although staffing numbers were linked to the number of people using the service, additional staff were provided when people's dependency needs increased and when people needed to be accompanied to an appointment. On the day of the inspection an extra care worker was employed to support people with social activities. Some people's relatives spoke of the lack of continuity of staff. A person's relative told us that there were, "Lots of new staff. Different faces when I visit, and I don't know their names."

Systems were in place to monitor the safety of the service. Records showed necessary checks such as gas checks, fire checks and electrical checks were carried out. The service had a fire risk assessment and fire drills took place. People had personal emergency and evacuation plans (PEEPs) which detailed the support people would need if the building needed to be evacuated in an emergency. The service had an emergency plan which specified the arrangements in place for responding to a range of emergency events such as gas and water leaks. People's relatives told us that they didn't have concerns about people's safety. A person's relative told us, "I am not worried about [person's] safety."

Accidents and incident records indicated that they were addressed appropriately. Staff understood their responsibilities to report and record incidents. Records showed that accidents were reviewed regularly, and that the number of falls had reduced, but that these checks did not always record the action taken to prevent reoccurrence. The consultant operations manager told us they would ensure that future checks included an action plan to minimise the risks of further accidents.

Systems, processes and practices to safeguard people from abuse were in place. Staff told us that they would report any concerns about people's well-being or safety to the management staff. They also knew that they could report allegations and suspicion of abuse to the host local authority safeguarding team, police and the CQC. A care worker knew about whistleblowing procedures and told us that they would

report any poor practise from staff. They told us "Where residents are concerned, I would protect them one million percent."

We reviewed the systems that the service had to ensure people were protected from the risk of infection. The premises were clean. Staff had completed infection control and food hygiene training. Protective clothing including disposable gloves and aprons were used by staff when assisting people with personal care to minimise the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us that they felt supported by management staff. However, records showed that a nurse had only one formal one to one supervision meeting in 2018, and that six staff had not received formal supervision at all in 2018. No staff had received an appraisal of their performance and development in 2018. This indicated that staff did not always receive the support and direction that they needed to ensure people always received a safe and good quality service.

Staff told us that when they had first started work they had received an induction, which had included shadowing more experienced staff whilst they provided people with care and carried out other tasks. A care worker told us that their induction had been helpful in getting to know the service and preparing them for carrying out their role and responsibilities. However, there were no induction records for five staff, which indicated that their competence had been effectively assessed by the provider.

Training records indicated that staff had received a range of relevant training, so that they had the knowledge and skills to meet people's needs and to keep them safe. A care worker told us that they had received "lots of training", which was "very good." They also told us that they were regularly reminded to complete 'refresher' training. A care worker spoke of the importance of keeping up to date with current practice and other matters to do with their role. They told us, "We need to be aware of what is happening out there." Some care staff had achieved relevant vocational qualifications in health and social care.

However, six people using the service lived with diabetes (a condition that causes a person's blood sugar level to become too high), and we found that care staff were not knowledgeable about the condition. Staff had not had the opportunity to complete learning/training about diabetes to support them in providing people with the care they needed and to gain an understanding of its symptoms. The operations manager told us that they would address this shortfall.

The above issues are a breach of Regulation 18 (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans and other records included information about each person's health needs and showed that people's healthcare needs were monitored by staff and community healthcare professionals that included GPs, chiropodists, tissue viability nurse, and opticians. The consultant operations manager told us that the service had difficulty accessing dental treatment but would seek advice from relevant services. A healthcare professional told us that staff followed their advice regarding people's treatment. People's relatives told us that, "They [staff] let me know when [person] was unwell. They keep in touch about [person's] appointments" and "[Staff] seem to know what they are talking about, and what they are doing. They explain everything they do. They are all very nice."

A choice of drinks was available. We heard care staff asking people what they would like to eat and drink. People had mixed views about the meals. One person using the service told us, "Sometimes food isn't too good and I can ask my [relative] to buy food from outside." Another person told us "If [the main cook] is here,

then [the food is] good." A third person using the service was very complimentary about the lunch they received and told us that the meal was "good." The cooks had knowledge and understanding of people's varied dietary needs including cultural food preferences. A cook told us that they asked for people's feedback about the meals but had not documented it or the action that they had taken in response to people's feedback for some time but would in future do so.

People were provided with assistance with their meals when they needed it. In the dining room, we saw staff engage in a relaxed and friendly manner when they assisted people with their meals. We saw that a care worker understood a person's nutritional and dementia care needs. They encouraged a person who was living with dementia to eat their meal despite the person at first refusing it. The person was asked by the care worker if they wished to move to a quieter setting and offered a different meal, which the person then ate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We saw that people's capacity to make decisions about some specific matters to do with their care and treatment such as to do with medicines had been assessed.

Staff we spoke with had some knowledge of the MCA. They knew that decisions could be made by healthcare professionals with family and staff if people did not have the capacity to make particular decisions. Staff knew to report to nurses and/or the manager if they found people's ability to make day to day decisions about their care and treatment had changed. We heard staff ask for people's consent before providing support. We saw a record of a decision for a person to wear a lap belt when using a wheelchair had been made in the person's best interest by staff to minimise the risk of the person being harmed.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS). Records showed that for some people DoLS had been authorised and that applications made for renewal of DoLS had been made by the service.

Since the last inspection bedrooms on the ground floor had been refurbished and the passageway on the ground floor had been redecorated. New flooring had been laid in the lounge and dining room. Chairs in the lounge were 'tired looking'. The consultant operations manager told us that there were plans to replace the 'tired looking' chairs in the lounge. A person's relative told us that they thought the premises could do with "modernisation."

Records showed that a range of maintenance checks were carried out. These included checks of windows, call bells, and hot water temperatures. Shortfalls were identified; however, maintenance checks did not include an action plans to show that any deficiencies found had been reported to management staff and addressed. Shortfalls that had been identified in earlier checks continued to be noted in following checks. For example, hot water from a tap in a vacant bedroom had been recorded as outside the safe temperature range during several checks. There was no indication from records that action had or was being taken to address this. The consultant operations manager told us that they would contact a plumber and would ensure that the issue was addressed promptly before anyone was admitted to that bedroom, and also develop a system to ensure that maintenance issues were resolved. Care staff told us that some people's beds were at times difficult to raise and lower.

Good

Is the service caring?

Our findings

During the inspection there were 14 (15 on the afternoon of the second day) people using the service. Throughout the inspection there were never more than six people using the communal areas. The rest of the people using the service remained in their bedrooms. A person's relative told us, "They don't encourage my [relative] to sit in the lounge." However, another person's relative told us that staff had tried "to coax [person] to go to the day room, but [person] didn't want to do it." Some people we spoke with told us that they preferred to spend their time in their bedrooms rather than sitting in the lounge. The consultant operations manager told us that staff had been reminded to ensure that they always offered people the choice of spending time in the lounge.

One person told us, that they were worried about items that they obtained after their admission to the service and of the risk of them going missing or theft. We noted that although an inventory of people's possessions was documented when people were admitted to the service, people's inventories were not updated with details of items they gained after their admission to the service. An up to date inventory could make it easier to investigate claims to do with missing items. The consultant operations manager told us that they would ensure that the issue was addressed.

A person using the service told us that staff were kind and people's relatives spoke in a positive way about the staff. A person's relative told us, "They [staff] always seem caring." Another person's relative told us that they felt [person using the service] was "quite content." We observed caring interactions between staff and people using the service. Staff spoke with people in a polite and calm way when they provided them with assistance. During a morning 'walk around' handover we heard staff greet people and ask them how they were and how well they had slept. In the afternoon, we heard one member of staff asking a person how their day had been. They chatted to the person for a while asking about a visit that they had had and showed an interest in what the person had to say. A care worker told us, "Whatever we do we have to explain to the person, so they know what is happening, such as when we help a person to transfer or when we give them a drink."

Staff we spoke with told us about how they supported people to make choices, which included when they wished to get up, what they wanted to do, eat, drink and wear. People told us that they made 'day to day' choices, including choosing when to go to bed and what to eat. A person told us that they could have a bath or shower when they wished. A person's relative told us, "They encourage [person using the service] and look after [person]."

We observed staff knocking on bedroom doors and respecting people's dignity and privacy, by closing curtains and doors during personal care. People using the service had the option of having their door left open or closed whilst in their rooms. A person using the service told us, "They always knock at the door; I can have my door open or shut." The office, which contained a range of records was locked when not in use. Staff were aware of the importance of confidentiality. They knew not to speak about people to anyone other than those involved in their care. People's care records, staff records, and other documentation were stored securely.

Before the inspection, we had received information that indicated people did not always receive their own clothes back from the service's laundry. We found that the service had taken action to address the issue by labelling people's clothes with their room number. However, this did not support people's dignity and a personalised approach. There was also the risk that if people changed rooms their clothes could be mislaid. The consultant operations manager told us that they would review and improve this practice.

People were supported to maintain relationships with family and friends. People's relatives told us that they had no concerns about the way staff engaged with people. They also told us that staff kept them informed of any changes in people's health or wellbeing. A person's relative told us that they visited a person using the service at different times of the day, and commented, "It is not an issue if I turn up at any time. Staff are always welcoming. Staff seem to care about [person] and like [person]."

Staff were aware of the importance of respecting people's diversity and human rights. A care worker told us that it was important, "To treat everybody equally, whether there were differences in sexuality, gender and race, it doesn't matter, they should be treated with respect." People using the service and staff confirmed that festive occasions and people's birthdays were celebrated by the service.

Most people had significant mobility needs. Wheelchairs and walking frames were available to support people to move about within and outside of the home. Equipment was used by staff to assist people with transferring, such as from their bed to the person's wheelchair.

Requires Improvement

Is the service responsive?

Our findings

People received an assessment to identify their needs before moving into the home. Their care plans were developed from these assessments to give staff the information and guidance they needed to meet people's needs. People's care plans covered areas that included communication, nutrition, mobility, social activities and medical conditions. However, the level of detail in people's care records was inconsistent and did not always include detail to ensure that staff had the information that they needed to meet each person's needs in a consistent way. For example, one person had a urinary catheter, was insulin dependent and had a mouth care regime but there were no care plans to guide staff about how to meet those needs. Also, despite there being some information displayed on the wall of a person's room about them needing mouth care, there was no evidence that the person was receiving this care. There was no equipment provided to enable staff to carry out mouth care and records did not show that mouth care was being provided. We raised our concerns with the nurse on duty who addressed the issue.

People's care documentation was not always personalised. There were no specific care plans that detailed how the service needed to meet the needs of people living with dementia, diabetes and those whose assessment had shown that they were at risk of falls. A specific tool was used to assess people's risk of developing a pressure ulcer. However, when people were found to be of risk, care plans that detailed how to minimise and manage that risk had not been put in place. A person's first language was not English, and their verbal communication was limited, but no care plan, word translation information, and other guidance to help staff meet those needs.

Some care records were not fully completed. For example, in one person's care file, the person's life history, list of belongings, personal contacts, maintaining safety information and consent for photographs records had not been completed despite them having been living in the home for a few months. People's care plans included the document 'This is Me' which when completed, provided staff with comprehensive information about the person using the service including details about their background, work history, family and life experiences. However, the 'This is Me' documents that we looked at were partially completed or blank and there was no record that detailed why those histories had not been completed. This personal information could be effective helping staff to get to know each person and better understand their individual needs and preferences.

The care plans that we looked at did not show that comprehensive reviews of people's needs, with their and where applicable family involvement, had taken place. There was no indication that changes in people's needs were reflected in the monthly reviews, or details of personal goals that they might have wanted to achieve. Most of the records of monthly review evaluations consisted of comments such as "no changes." A person's relative told us, "I haven't been invited to a review." People using the service we spoke with were not familiar with their plan of care.

The above issues are a breach of Regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection a volunteer from a charity sang religious songs with four people using the service. One of the care workers played a piano and other care staff encouraged people to participate in the singing. People also listened to music and did puzzles during the inspection. A person using the service told us, "I love music, I go to the lounge to enjoy [it] but in my room, I just watch television." Another person using the service told us, "They cut my nails and polish them whenever I want."

Photographs showed that some people using the service had participated in a community evening event. A care worker told us that they had accompanied people using the service to the event and spoke of people's enjoyment. The consultant operations manager told us that all but two people using the service had recently watched a pantomime put on in the home by a theatre group. A person's relative told us that once when they had visited their relative in the person's room, they had found a care worker engaging well the person, which they told us they thought was very nice. A care worker told us that people spent time in the garden during the summer months and barbeques had taken place. However, few people spent time in the lounge or dining area, and there was little indication from records and talking with people that people had the opportunity to participate in a variety of activities that met their personal needs and preferences to promote their well-being and minimise the risk of social isolation.

The accessibility of information to people using the service was looked at. Most information was in written format. It is now law for the NHS and adult social care services to comply with the Accessible Information Standard (AIS), to make sure that people with a disability or sensory loss were given information in a way they could understand. Information about the service was in mainly written format. We were informed by staff that there was a picture book that was available to help people to choose meals, but we did not see this used during the inspection. The consultant operations manager told us that she would consider ways of making information as accessible as possible to people.

The home had a system for addressing complaints. The complaints procedure was displayed. People's relatives knew who to contact if they wished to make a complaint and people we spoke with knew how to raise a complaint. Records indicated that there had been no complaints during the last twelve months. A person's relative told us "I have no complaints. It is all ok."

The service on occasions provided people with end of life care. The consultant operations manager told us that at the time of the inspection no person using the service was receiving palliative care. People's had 'End of Life Assessment documents' in their care files, but those we looked at had not been completed, and did not include advanced care plans that detailed people's future wishes and priorities for care at the end of their lives. These documents if completed could help staff understand and support people's individual preferences and wishes at the end of their lives, so provide them with the care that they wanted and needed, and possibly minimise hospital admissions.

Do not attempt resuscitation (DNAR) records, which had been completed by a doctor were seen in some people's files. However, it was not clear to all care staff how they would know when a person was not for resuscitation. Following the inspection, the consultant operations manager told us that steps had been taken to ensure all staff were aware of DNAR decisions.

Requires Improvement

Is the service well-led?

Our findings

People told us that the management team were approachable. People's relatives told us, "Service is okay, I know the manager," "I know [consultant operations manager] and [deputy manager], I am kept inform about [person's] health."

Staff we spoke with told us that they felt that improvements to the service were taking place. A nurse told us that teamwork had recently improved. A care worker also spoke in a positive way about teamwork and of communication between staff. Nurses told us that management staff were always available for advice and support.

At the time of the inspection the service was being managed by the consultant operations manager and deputy manager. Before this there had been a lengthy period of different managers in post, and no registered manager since August 2017. Management of the service had not been consistent, responsive and effective in preventing the shortfalls that we found.

We looked at the arrangements for monitoring, developing and improving the quality and safety of the service. We found that a range of checks were carried out. These included checks of the medicines, windows, bedrail, accidents, catering, hot water, fire alarm, health and safety checks, care plans, pressure ulcers, wounds, unplanned hospital admissions, complaints, safeguarding issues, accidents, incidents, infection control, maintenance and staff training. However, records of most checks showed that when shortfalls had been identified, there were no details to show if action had been taken to address the shortfalls found, mitigate risks and to prevent reoccurrence. Consequently, when checks were repeated the same or similar deficiencies continued to be identified.

Also, quality monitoring checks did not always take place within the provider's timescales. For example, monthly quality audits were not completed monthly. Records showed that three 'monthly audits', not twelve had been completed in 2018. A quarterly safeguarding audit had been completed twice in 2018. One catering audit had no record of who had carried it out. This showed that quality checks were not always effective in addressing deficiencies and in making improvements to the service.

There was a lack of effective systems to monitor people's needs and provide suitable guidance to help staff provide people with personalised care and keep them safe.

People's relatives told us that they were informed when there were significant changes in people's needs. Comments from people's relatives included, "They will tell me if [person] has not been too good. I am updated," "They keep me in touch" and "[Person] receives good care."

There were records that showed that some people's relatives had been asked for their views about the service in 2017 and had provided positive feedback. However, no records of more recent feedback from people's relatives or any feedback from people using the service were available. A person's relative told us that they hadn't been asked for feedback about the service. We saw one feedback form completed by a

healthcare professional, but that record was not dated.

Records did not show that people were provided with the opportunity to attend regular resident meetings and monthly reviews of their needs, where their views of the service could be obtained and addressed. Records did not show that staff had the opportunity to complete staff surveys. Staff also did not receive regular supervision and annual appraisals to monitor their performance and support their learning and development. The limited systems for obtaining views about the service did not support and encourage people to discuss and influence the operation of the service.

The above issues are a breach of Regulation 17 (1) (2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Since the last inspection a Closed-Circuit TV (CCTV) surveillance system had been put in place in the communal areas of the service for the monitoring of activity in those areas. Signs telling people that CCTV was in operation were clearly displayed. There was no CCTV policy that documented details and guidance about its use including details of the person or persons who have access to CCTV information, details about retention of information, the responsibilities of the service, action to take if there is a subject access request-freedom of information act and that the service must notify the information commissioner's office. The nominated individual informed us that a CCTV policy/procedure would be put in place.

The service had a range of other policies and procedures in place. The policies were accessible to staff. They included the guidance staff needed to follow and act upon in areas of the service such us responding to complaints and health and safety matters.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were not always protected as the care and treatment of service users did not always meet their needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with receiving the care or treatment including the proper and safe management of medicines. Regulation 12 (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected by effective recruitment procedures. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services were not protected as staff did not receive appropriate and necessary

induction, supervision, appraisal and specific training to support and develop them to carry out the duties they were employed to perform.

Regulation 18 (2) (a)

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People who use services were not protected as systems to assess, monitor and improve the quality of the service were not effective. Regulation 17 (2) (a) (b) (c) (e)

The enforcement action we took:

A warning notice