Mr Amin Lakhani

Glen Rose

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 26 and 17 April 2016.

Glen Rose provides accommodation and nursing care for up to 47 older people who are living with dementia and have nursing needs. The home has three floors, 31 bedrooms with 15 of these being shared rooms and three communal areas. At the time of our inspection, 21 people were accommodated in the home.

Although our register showed a registered manager was in place, this person had not been working in the home since February 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. One of the provider's general managers was providing the day to day management of the home, with the support of the director of operations. At the time of our inspection the general manager was not present.

People who lived in the home were not always able to tell us their views verbally. Observations demonstrated that people were not always treated with respect and offered choices. They were cared for in an environment that was unclean and not well maintained. Equipment was not always available and when it was, it was not clean. Staff had not consistently received supervisions and training to ensure they could be effective in their role and at times people were left alone for extended periods of time. We have made a recommendation about the deployment of staff and assessment of staffing levels. Not all risks associated with peoples care had been assessed and plans to reduce the risks developed. When risks presented, prompt action was not always taken and at times care plans were not personalised or followed by staff.

This placed people at risk of receiving care and support that did not meet their needs or placed them at further risk.

The systems used by the provider to monitor and assess quality had been ineffective and concerns had not been identified until these were raised with them.. A lack of effective quality systems places people at risk of receiving a service that in ineffective.

Staff demonstrated an understanding of the need for respect and consent. Where required, the Mental Capacity Act 2005 had been applied. We have made a recommendation about recording clarity for best interests decisions. Staff had a good knowledge of safeguarding adults at risk, and were confident to raise any concerns. Recruitment practices ensured staff were safe to work with vulnerable people. Medicines were managed safely.

We identified breaches of 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 this report.

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.

Risks associated with people's care were not always assessed and plans developed to mitigate such risks. When risks presented for people, prompt action was not always taken to reduce the likelihood of reoccurrence.

Premises and equipment were not clean and well maintained.

It was unclear how staffing levels were based on people's needs and we have made a recommendation about this.

Medicines were managed safely.

Safe recruitment practices were being operated.

Staff understood safeguarding people at risk and knew what action to take if they had concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported to be fully effective in their roles through supervisions and training.

People's nutritional needs were not always monitored and planned for effectively.

Consent was sought from people and where people lacked capacity to make certain decisions the Mental Capacity Act was applied correctly. We have made a recommendation about the recording of best interest decisions.

People had access to healthcare professionals when they required this.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff who demonstrated respect towards them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives confirmed their involvement in the development of care plans but these were not always personalised or followed.

A complaints procedure was in place and people knew how to use this.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor quality and drive improvement were not always effective and records were not always accurate.

A temporary manager was in place to support the service. Staff said they felt this person was approachable and supportive.

Glen Rose

Detailed findings

Background to this inspection

regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 27 April 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who had experience of working in social care and an Expert by Experience who also had experience of working with people living with dementia. Before the inspection we reviewed previous inspection reports and looked at our own records such as any notifications of incidents which occurred (a notification is information about important events which the service is required to tell us about by law). This information helped us to identify and address potential areas of concern.

During the inspection we spoke with one person and eight relatives. We also spoke to 12 staff including care staff, nurses, ancillary staff and activity staff. We spoke to the director of operations and the quality assurance manager. It was not always possible to establish people's views verbally due to the nature of their dementia. To help us understand the experience of people who could not talk with us, we spent time observing interactions between staff and people who lived in the home.

We looked at care records for eight people in depth and sampled the records of a further three people. We looked at the medicines records, recruitment, supervision and appraisal records for staff. We also looked at a range of records relating to the management of the service such as incidents and accidents, complaints, feedback surveys, meetings, audits, policies and procedures, and the staff training matrix.

Requires Improvement

Is the service safe?

Our findings

People's relatives felt they were safe, although one raised concerns with us about the cleanliness of their family member's room and another raised concerns with us about prompt and effective reporting of incidents and injuries.

At our last inspection we rated this question as requires improvement.

At this inspection we found at times, identified needs had not been assessed and plans developed to reduce risks. For example, one person's care records indicated a history of behaviours which presented a risk to themselves and others. However no assessment of these behaviours had occurred and no plans had been developed to meet and reduce any risk.

Where risks had been identified and plans were in place which gave clear guidance, we could not see these were always followed by staff. For example, a second person's care records stated they should be repositioned every two hours. However, on the second day of our visit there was no evidence that whilst this person was seated in a chair they were repositioned at all for a period of four hours.

A third person's care records detailed the use of equipment to assist them to move. This detailed how this was to be used to ensure the persons safety. However, on the second day of our visit we observed two agency workers attempting to use this equipment incorrectly. They did not follow the care plan. A third permanent member of staff provided the agency workers with support. The failure to follow the persons care plan placed them at risk of receiving an injury.

When risks presented, assessments were not always reviewed promptly with action planned or taken to reduce risks occurring. For example, one person had an accident record contained within their records that showed an injury had occurred as a result of the use of a piece of equipment. This incident had not triggered a review of the risk assessment and no action had been taken to prevent a recurrence. On the second day of our visit the incident reoccurred. The person suffered no visible injuries on that occasion, but prompt action following the previous incident could have prevented that incident occurring.

At times care plans gave incorrect guidance to staff that would be needed in an emergency. For example, one person's care plan told staff that the suction machine was located beside the nurses desk in the nurses station should this be needed if the person choked. However, this machine was not stored in this room. Three machines were stored on the top of a cupboard on a different floor of the building. Two were out of date and could not be used.

The failure to ensure that identified risks were appropriately assessed, with plans implemented to reduce risks, the failure to ensure plans in place were followed and the failure to take prompt action when risks presented was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also found areas where risks had been assessed and clear plans developed to guide staff. For example one person who had a diagnosis of diabetes had clear guidance about this condition, the risks associated and the action staff should take. Another person's care records provided clear information about the risk of choking and the action staff should take to minimise this risk and also the action to take should an incident of choking occur.

Areas of the home and items of equipment were poorly maintained and unclean. For example, on the second day of our inspection we found the inside cover of two pressure cushions in the ground floor lounge area were heavily stained and the zips contained food debris. In the first floor lounge one pressure cushion zip would not work so could not be opened to be cleaned and a second was heavily stained inside. Three fall out chair (these are chairs designed to prevent people from falling out of them) seats contained food stains and crumbs on the fabric, under the cushions. A rotunda stand aid was heavily stained. The flooring on the ground floor shower room was heavily stained. A sink seal was broken and when an inspector placed a small amount of pressure on the edge of this it moved forward, the flooring in this room was not sealed fully. A radiator cover in the lounge area was not fully secured to the wall and a table was pushed against it. However, we observed a person moving the table on the first day of our inspection. The base of bath unit on the first floor was thick with dust. Whilst we were told this was being used we subsequently found out it had not been in use due to a faulty part since March 2016 and was condemned on the first day of our inspection. The bed bumpers in one double room were stained and one of these was worn. The wall that one of the beds was leaning against was stained with a liquid substance. We were able to pick food off the only working suction machine. It was generally very dirty. The tube to be attached to the machine and used for suction was stained yellow. Staff did not know if there were any more clean sterile tubes at the home.

There was insufficient equipment to meet people's needs. Staff told us eight people required fall out chairs but there were only five available. They said this meant if all eight wanted to get out of bed at the same time they would not be able to. Staff told us only one stand aid was available which was shared across both floors, and this made it difficult at times as they needed to wait for this to become available. Staff said that there were two generic wheelchairs per floor for people to use. However, we saw one person required one of their own or for one to be adjusted appropriately to meet their needs.

The failure to ensure premises and equipment was clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2015 we found staffing levels were not sufficient to meet people's needs at all times. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this and they sent us an action plan and an improvement plan. These told us that they had reviewed their staffing levels and introduced a new role to the team of staff.

At this inspection staff and relatives felt there were enough staff available to meet people's needs. We observed that the staffing levels had not changed since our last inspection in January 2015, although the number of people living at the home had reduced from 37 to 21. There were six care staff on duty until 2pm when this reduced to five. A minimum of two registered nurses were on duty throughout the day; although on our second day of inspection there were three registered nurses, one of whom we were told was providing observational support to a newly recruited nurse. In addition, the social care manager was also present and working on a supernumerary basis as the manager was on annual leave. An activity coordinator who worked 9am – 4pm Monday to Friday was also on duty.

The provider used an assessment tool called Waterlow alongside three other guidance documents to

determine the staffing levels needed. The primary aim of a Waterlow assessment is to assist in the assessment of the risk of a person developing a pressure ulcer and is not a recognised tool to assess staffing needs. The Waterlow assessment score produced a total number of hours that a person required each day. For example, a very high score on a Waterlow equated to five hours of support per 24 hours. However, it was unclear how this number of hours had been determined. This was then totalled to provide an overall number of care hours needed over a 24 hour period.

Whilst the document produced by the providers senior management team showed the number of hours of staffing provided for March and April 2016 was in excess of the hours identified by the Waterlow score, some of our observations identified some concerns regarding staffing. For example on one occasion we observed a person seated in the first floor lounge area for a period of 20 minutes alone. No staff entered this room and the person had no way of calling for their help should they need it. At that time, staff were providing personal care support to other people in their rooms. During lunchtime on the ground floor we observed one person seated at the table for a period of 30 minutes before a staff member offered them their meal. During these 30 minutes all staff present were supporting other people with their meals. On another occasion we observed a person seated alone in the first floor lounge for a period of 15 minutes. They were shouting out and appeared to be trying to scratch their face. Staff were supporting other people in their rooms at that time and did not respond to these calls. When staff did respond after 15 minutes, the person began to smile, laugh and appeared more settled.

We recommend the provider review the deployment of staff and the system and tools used to assess people's dependency and determine the required staffing levels.

The director of operations told us they had changed the system used for the administration of medicines following a medicines error. Registered nurses administered all medicines in the home. Medicines were stored and handled safely. People received their medicines in a safe and effective way. There were no gaps in the recordings of medicines given on the medicines administration records. There were body maps in people's rooms where needed, indicating when and where topical creams should be applied. Nurses checked each other's medicine records after each time they were given to see that all had been signed for. At night a member of the care staff would check them as only one nurse worked at night. There were protocols and guidance in place for 'as required' medicines. Fridge and room temperatures were checked to ensure medicines were stored at safe temperatures. There were appropriate procedures in place for the disposal and return of medicines.

Staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults at risk. They were able to describe different types of abuse and the action they would take if they had concerns. Where concerns had been raised the senior management team had investigated these and produced lessons learned.

The recruitment process ensured new staff were of good character and were suitable to carry out their role. Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Appropriate checks were undertaken before staff began work. This included Nursing and Midwifery Council (NMC) checks. All nurses have to be registered with the NMC to be able to work. The NMC monitors nurse's work and offers guidance to them to practice. The provider received information regarding agency staff employed to work at the home. This included a photograph, their position and a list of their training. We were told that there was a volunteer working at the home and the home had requested two references and a DBS check. They also had received checks regarding the hairdresser.

Requires Improvement

Is the service effective?

Our findings

Most relatives told us they felt their family members were well cared for by staff who were knowledgeable. One said they thought their family member was well known to the staff and felt that they were well trained enough to give effective care to them. However, one told us they felt they often had to chase staff to make a request for GP visits and that staff were not proactive enough.

At our last inspection we rated this question as requires improvement.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our inspection in January 2015 we found the registered person was unable to demonstrate that best interests' decisions had been undertaken when a person had been assessed as lacking the capacity to make a certain decision. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this and they sent us an action plan and an improvement plan.

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff demonstrated an understanding of the need for consent, although their understating of the Mental Capacity Act 2005 varied. Where needed, assessments of people's capacity to make certain decisions had been undertaken and these also recorded the best interests decisions. However, at times the records of best interests were unclear as they did not record who was involved or their views. Relatives we spoke with were able to confirm their involvement in these best interests decisions and said staff at the home always involved them in their family members care.

We recommend the provider review the way in which they record best interests decision making.

The director of operations demonstrated knowledge of Deprivation of Liberty Safeguards (DoLS) and understood their responsibilities in relation to this. Applications to the supervisory body had been made and we saw where required these had been reviewed. Where conditions had been set as a result of an authorised DoLS, action had been taken to meet these conditions.

Staff we spoke with told us that they had had an induction before they started work on their own and described this as thorough. They said they spent time undertaking training and shadowing other staff before being allowed to work independently. Registered nurses had to observe and be observed administering medicines before they were able to do this on their own. Care staff were required to undertake the Care Certificate and courses on these standards were arranged over the year in quarterly blocks so that staff could choose when to attend. The Care Certificate familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life.

At our last inspection in January 2015 the general manager was open and transparent, sharing with us that staff supervisions and appraisals had not taken place. They had plans to ensure this improved. At this inspection staff told us that that they had received some supervision meetings and had been observed as part of their induction. They were positive about both supervision and observations describing how it supported them in their role and in keeping them up to date. There were records of staff practice observations and supervision meetings. This reflected that five of 15 care staff and one of four registered nurses had not received any supervision or practice observations. A second nurse had not received supervision for over a year.

A training matrix was held by the general manager and the director of operations provided us with a copy of this. This showed most staff had received training in first aid, food hygiene, moving and handling, fire, health and safety, infection control and safeguarding. However, it showed that only one of 15 care staff and only 1 of four nurses had undertaken Mental Capacity Training. No staff had received training in challenging behaviour, despite supporting a number of people who may display these types of behaviours. We identified some concerns about how incidents of challenging behaviour were managed. Registered nurses were responsible for developing care plans and assessing risks yet the training matrix showed no registered nurses had received training to do this effectively. We identified some concerns regarding the assessment of risk and care planning.

The failure to ensure staff were supported to be effective in their roles through supervisions and training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2015, the environment was not always conducive for people living with dementia and we made a recommendation about this. The provider sent us an improvement plan which said "name signage to be improved on bedroom doors, other areas identified by signage, dining room arrangements to be improved, lighting in all areas to be checked and improved where possible and future decoration of the home to ensure a more dementia friendly environment in respect of colours and further signage". We saw during this inspection that lighting in the corridor appeared brighter. However the use of visual aids to support people living with dementia to recognise the functionality of rooms and equipment were not sufficient. Signage had been implemented, however, these were small and written words. No pictorial signage was in use on the ground floor where bedrooms and communal areas were found and one pictorial sign was used for a room, on the first floor. At the last inspection we found people's names were on their bedrooms doors, however, this was in small letters and very high up, which made it difficult to read. This had not changed at this inspection. At our last inspection we found at meal times the dining area was sparse. Tables were bare, with no cutlery, table clothes or condiments. The lack of visual connections for people with dementia would make it difficult to recognise the purpose of this area. At this inspection, this had not changed.

The failure to ensure premises were suitable was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat and drink. We observed people being offered a choice of lunchtime meal in the morning. This was presented to people verbally. As most people's communication was restricted due to their dementia, it was a concern that no other alternative form of communication was used to show people what was on offer. The cook had a four week rolling menu although staff told us this had not changed for years. The kitchen staff were fully aware of people's needs in relation to their likes, dislikes and type of meals they should be having. They described to us how they ensured foods and drinks were fortified if a person was losing weight. People had care plans associated with eating and drinking, including their preferences and the support they required. Where the person was at risk of choking this was referenced.

At our last inspection we found the monitoring of peoples nutrition and hydration needs were not as effective as they could be. The provider sent us an improvement plan which told us "Staff have been encouraged to be more aware of appropriate fluid intake and fluid charts are now being totalled and assessed by the nurse in charge for further action". However at this inspection we found the care plans did not provide any guidance about a person's ideal or target food and fluid intake. Charts had been implemented for some people whose food and fluid intake required monitoring; however these were not always effective. For example these contained no guidance about their ideal food and fluid intake. At times the fluid intake charts had not been totalled and when fluid intake appeared low we could not see any evidence this had been evaluated and action taken to address this. Staff told us this was handed over to them by the night staff and they would encourage the person to drink more the following day. The records of food intake did not always say what the food was, or how much was provided. This meant a person's actual nutritional intake could not be established. A lack of guidance about a person's ideal intake and ineffective monitoring that was not evaluated means staff would find it difficult to monitor if people's individualised nutrition and hydration needs were being met. This had not changed since our last inspection.

The failure to ensure effective monitoring and planning of people's individualised nutrition and hydration needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records confirmed people had access to a range of health care professionals including opticians, dentists, GP, speech and language therapists and specialist nurses. We saw advice from these professionals was used to inform and update care plans for people.

Requires Improvement

Is the service caring?

Our findings

One person told us "staff treat me OK', and said that they were able to have a laugh and a joke with staff. Relatives told us they felt staff were kind and caring. One said the atmosphere was homely and 'the staff are marvellous'. A second said they felt staff were kind, had a sense of humour and communicated with their family member well.

At our last inspection we rated this question as requires improvement. The provider sent us an improvement plan which said "all staff had received a copy of good practice guidance developed by the home. Observation audits had been completed and any issue raised had been addressed with staff. A staff meeting had been held to discuss the last inspection report and to encourage staff to suggest improvements. Basic care information was available in people's rooms as guidance for staff, hard copies of care plans were in folders in the nurses station but accessible to staff and visitors as requested. Computerised records were on a safe site." We did not find improvements had been made.

At this inspection we found improvements had not been made consistently across this key area. Staff were able to describe the importance of respecting people's privacy and dignity. They were able to tell us some of the things they did to ensure this, such as knock on doors and make sure curtains and doors were closed when delivering personal care. However, whilst staff were able to talk about this we also observed some practice which reflected people were not consistently treated with respect.

For example, we were told of one person who required a 'fall out chair' at all times when they were not in bed. We saw this chair in the person's room on the second day of our visit and the staff member told us this would be used when the person got up. However, another member of staff entered this person's room and took this to use for someone else. They did not communicate this to the staff supporting people on this floor. Removing the equipment this person needed without consultation demonstrated a lack of respect for that person.

On a second occasion, a member of staff asked two people if they wanted a film put on, there were five people in the lounge. The member of staff already had a film in their hand and it was this film that was put on. No choice was offered. At lunch time a silent film was put on the television and music was playing. Staff told us some people liked music and others liked to look at the television. People were not given a choice of film or music.

On another occasion we observed one person with their eyes closed seated in a chair. A member of staff approached them with a cup and placed the cup against their mouth while their eyes remained shut. The member of staff then rubbed the person's arm quite firmly to try and rouse them. This was unsuccessful so the member of staff placed the drink on a table next to them and walked away. We saw a member of staff trying to feed someone who had their eyes closed, the member of staff did talk to them and they put the spoon of food right up against the person's mouth without them opening their mouth. The member of staff then had to wipe away the food.

We saw one staff member attempt to put a clothes protector on a person. The staff member did not communicate this to the person or offer them a choice. They just went to place it on them. This person became cross and shouted, "what are you doing". The staff member responded by saying "Okay I will do it later." This member of staff also went to remove this person's main meal without communicating with them. The person quite loudly told them, "I have not finished."

We observed one occasion when a person was moving a chair which another person was seated in. Staff initially checked the brakes were on and then returned to what they were doing. No attempt to communicate with either person was made. The person continued to move the chair and after approximately three minutes staff attempted to distract the person. At no point throughout this did any staff member offer any reassurance or explanation to the person seated in the chair.

The person moving the chair became agitated when staff tried to prevent them from doing so. One member of staff responded positively and calmly, using distraction techniques. However, the other member of staff did not take this approach and used their body to block the person's access to the chair, resulting in the person becoming more agitated and displaying physically challenging behaviours towards the staff member.

The failure to ensure people were treated with dignity and respect at all times was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

However, we also observed some kind, caring and respectful interactions. On one occasion whilst supporting a person to move, we observed kind and clear dialogue about what was happening between the staff member and the person. On a second occasion we observed very compassionate and kind approach by one staff member to a person who was clearly distressed.

Relatives meetings were held; although there were only records of one being conducted in the last 12 months. This had recently taken place and we saw records which confirmed that those who attended were kept updated of changes that had taken place in the home and asked for any suggestions and comments about the service.

Requires Improvement

Is the service responsive?

Our findings

One person told us they were aware of their care plan and had contributed to this. Relatives told us they were involved in discussion with staff about their family members care and felt the staff responded to people's needs well.

At our last inspection we rated this question as requires improvement. The provider sent us an improvement plan which said "a) all care plans have been extended and reviewed to ensure peoples current needs are identified and addressed". We did not find care plans reflected peoples needs and preference or that they were consistently followed.

At this inspection, staff had knowledge of person centred care, and were able to tell us what this meant. They said they were aware of people's care plans and felt these provided sufficient information to support them in their role.

Care records included information about people's history, including their personal and medical history. Information about people's likes and dislikes was also maintained. Some care plans had been personalised and reflected people's needs and preferences. Relatives told us how they were involved and asked about their family members care. However, we were not sure this information was always used. For example, we found one care plan recorded how a person preferred tea with one sugar when their family had provided information that they preferred strong coffee with sugar. We observed this person being given juice with no choice offered. A further care plan recorded this person preferred a bath, their profile recorded they preferred a shower and the daily records completed by care staff reflected they were provided with a bed bath. We discussed this with the director of operations who said they believed bed showers were used. However this was not reflected in the records. For a second person a document titled 'My life, my experience, my journey' provided by the family advised staff that 'when I am unwell I do not always get a temperature, I do get flushed, agitated and go off food and drink.' We did not see this guidance in the persons care plans. On the second day of the inspection when this person did not want to eat their lunchtime meal, we did not hear staff discuss that they may be feeling unwell.

Care plans were not always followed. For example, for a third person the care plan listed passive exercises for staff to support the person to do and it stated "Ensure before procedures [name] has received pain relief 20 minutes before." Daily records did not show that passive exercises were being given or that pain relief was administered beforehand. When we looked at the medicine records and spoke with nursing staff they told us that the person was not prescribed any pain relief. This meant that the care plans did not hold the right information for staff to support the person or that staff were not developing the care plan to meet the person's needs.

For a fourth person their care records stated that they liked to wear a hairband every day. On the first day of the inspection they were wearing one but not on the second day. Their care records stated they liked having their doll with them at all times and became upset if it is referred to as a doll not as her baby. It stated "This is very important and it's most important that all staff are aware." On the second day of the inspection a

member of staff spoke with the person about their doll and said they would help them change the clothes. The doll and bag of clothes was observed to be in a chair away from the person. The person was assisted to their bed to rest after lunch and the doll remained in the lounge. Care staff were not following the advice in the care plans.

The lack of accurate, clear, person centred and individualised plans available for agency workers and new staff, meant people may not receive care and support in a way they require. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other plans of care for people were person centred and adhered to by staff. For example, one person's plan described the need to use large bright items as distraction tools and we observed these being used. Another person's provided clear information about the management of their catheter.

The provider had a complaints procedure displayed in the home. Most relatives told us they did not have any complaints and would feel comfortable and confident raising concerns. They described the general manager in a positive manner. However, one person's relative expressed dissatisfaction in the care their family member received, although they said they had not raised a complaint for fear of reprisal for their family member. A record of complaints, concerns and compliments was held. We noted that the complaints recorded related to anonymous concerns sent to the provider by external agencies, or related to incidents that had occurred which the manager had investigated. We saw all of these were investigated by the manager and/or director of operations. External agencies including the Commission were kept informed of the outcome and any learning the provider had taken as a result.

Requires Improvement

Is the service well-led?

Our findings

Staff told us how they felt supported in the home, and that the service in general was improving. One staff member told us the management team were supportive. A person said the general manager; "is marvellous creature and place would fall apart without her. " A relative said that the management team had made improvements lately, replacing old carpet with laminate flooring.

At our last inspection we recommended the provider seek guidance from a reputable source about effective auditing of service provision because some of the systems in place did not always ensure people's care plans reflected their needs. We rated this question as requires improvement. The provider sent us an improvement plan which said "a) more robust audits have been used to help identify any issues. Regular observation visits have been used to identify issues and immediate action taken as required. b) regular staff meetings are being held to keep the staff informed of updates and any changes ". We did not find that the systems used were effective.

At this inspection we saw the provider had reviewed the system they were using to ensure the quality of the service. However, we remained concerned about its effectiveness. Numerous audits were conducted including, falls, incidents, infection control, dignity in care and clinical /care support audits. Some of these audits were conducted by the home manager including falls and incidents. We looked at the audit regarding falls and found this information was not accurate. For example, the audit period 6 Jan 2016 to 11 April 2016 showed five falls for one person when their records showed they had six. One of these falls related to the use of equipment. No review of the equipment's usage had been undertaken following this fall and a further incident of this nature occurred while we were inspecting. The audit section titled 'further action' against this fall was blank. This had been ineffective in identifying the risk and taking appropriate action.

Other audits were carried out by the senior management team. The person employed to manage quality assurance told us they scheduled visits to services by the senior management team to conduct the audits. Following these visits an action plan was produced and further visits were now being scheduled six weeks later to review the action plans. However, we were concerned that these audits were not always effective in identifying areas that required improvement or subsequently ensuring the actions were taken promptly.

For example, the dignity in care audit conducted on 4 April 2016 stated that "all care plans are PCP [person centred plan]. Care is given as per the CP's [care plans]". However, we found one care plan recorded how a person preferred tea with one sugar when their family had provided information that they preferred strong coffee with sugar. For another person their care plan gave detail about a specific need that we found was not being followed or was inaccurate. This audit also stated that bathing needs/preferences are noted in the personal profile and also in the care plans. However the care plan recorded this person preferred a bath, their profile recorded they preferred a shower and the daily records competed by care staff reflected they were provided with a bed bath. An effective audit would have identified these concerns but this had not.

The clinical/care support audit conducted on 12 January 2016 stated that 15 care plans were sampled. This

identified that "Not all clients have behaviour plans". A review dated 1 March 2016 stated "Relevant ones now in place". However, we found for one person, information in their care records suggested they could display physically challenging behaviours towards others. There was no review to suggest this was no longer an issue and no plan had been developed.

This audit also stated that pressure area care plans needed to be in place. The review dated 1 March 2016 stated "these continue to be completed". We found one person whose records and equipment used indicated a care plan was needed to prevent pressure area breakdown and maintain skin integrity. However no plan was in place. An effective audit would have identified these concerns but this had not.

An infection control audit carried out on 4 April 2016 identified some of the areas we identified as a concern during this inspection, for example, the ground floor shower room required cleaning. The audit action plan stated this room was stained and highlighted this as "urgent action required". We saw grouting between the floor tiles of this room were heavily stained at the time of our visit. The audit identified that no records were in place to show when equipment including mattresses, bed rail bumpers, hoists, wheelchairs and other items were cleaned. The audit identified this as requiring action. The director of operations told us these had been completed and they had seen these. However, they were unable to find these to show us. Records of cleaning of bed rails, bed bumpers, mattresses and wheelchairs were subsequently sent to us. However the audit did not identify a lack of cleaning of moving and handling equipment, pressure cushions and chairs which we found to be unclean.

Feedback had recently been sought in the form of surveys. These had been analysed in March 2016 and action plans developed. Resident feedback had been returned from three people. All three had stated they were not consulted about their care plan. All three rated the cleanliness of the environment as 'not good'. Two people felt their views and comments were not always listened to and acted upon. Despite this feedback, there was no action planned to address these. Relative's feedback had also been sought through the use of surveys and six had been returned. One relative had commented that more staff were needed. The response documented that the 'staff calculations continue to ensure adequate staff on duty'. There was no evidence this had been explored further or that the provider intended to explore this further.

The failure to ensure systems used to assess quality and drive improvement were effective was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings had not taken place regularly. The last recorded staff meeting had been held in March 2016 and we saw the general manager used this as an opportunity to encourage staff to discuss any concerns with them and make suggestions. Staff stated that they felt things had improved and the general manager supported them well. They described this person as firm but fair. Staff said they were approachable and always willing to listen. They said where things could change they supported this but where they could not, an explanation was always given.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensure care was designed and delivered to meet the individualised needs of people. Regulation 9 (1)(b)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that risks associated with peoples care were effectively assessed and action was taken to mitigate these. Regulation 12(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured there were enough suitable supported and trained staff to meet people's need at all times. Regulation 18(1)(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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect at all times. Regulation 10 (1)

The enforcement action we took:

We served a warning notice on the provider requiring them to take action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensured the environment was clean, well maintained and suitable for its purpose. Regulation 15(1)(a)(c)(e)

The enforcement action we took:

We served a warning notice on the provider requiring them to take action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured effective systems were in place to assess quality and ensure improvement. Regulation 17(1)(2)(a)(b)(e)

The enforcement action we took:

We served a warning notice on the provider requiring them to take action