Golden Manor Health Care (Ealing) Limited

Upper Halliford Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 8 January 2015 and was unannounced.

The service provides accommodation, nursing and personal care for up to 62 older people, some of whom are living with dementia. There were 52 people living at the home at the time of our inspection.

There was no registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run. The previous registered manager had resigned in December 2014. The provider's Regional Manager was managing the service on a day-to-day basis at the time of our inspection.

Summary of findings

People's safety was being compromised in a number of areas. There were not enough staff to keep people safe and meet their needs in a timely way. People routinely had to wait for long periods when they needed care or support. Medicines protocols were not always followed and people's medicines were not always managed appropriately. People were not kept safe by the provider's recruitment procedures. Allegations of abuse had been reported when necessary but the provider had not always investigated incidents appropriately when required to do so.

People did not receive consistent care from staff who knew their needs well. Some staff did not have sufficient knowledge of people's needs to ensure that they received the care they required. Some people did not receive the support they required as care plans did not reflect people's needs and were not always up to date.

People had not always given their consent to the care they received and the provider had not consulted relevant others to ensure that decisions were made in people's best interests. Staff did not have an adequate knowledge of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

The service did not have adequate management or leadership. A culture had developed within which some staff felt bullied by others and did not feel adequately supported by their managers. Complaints made by people living at the service and their relatives were not managed or investigated appropriately.

People did not have sufficient opportunities to take part in activities or to engage with others, which meant that they were at risk of social isolation. The premises had not been adapted to meet the needs of people living with dementia. The provider's quality monitoring system was not effective as concerns identified during our inspection had not been captured through monitoring visits. Where the provider had identified shortfalls through the quality monitoring process, they had failed to take action to address these concerns.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were not enough staff to keep people safe and meet their needs in a timely way. Nurse call bells were not responded to in good time and people routinely had to wait for long periods when they needed care or support.

People were not kept safe by the provider's recruitment procedures. The provider had not considered the risk to people of employing applicants previously convicted of criminal offences.

Medicines protocols were not always followed and people's medicines were not always managed appropriately.

Staff did not have adequate knowledge of the equipment available for dealing with medical emergencies or sufficient training to use the equipment effectively.

There were procedures for safeguarding vulnerable adults and staff were aware of these.

Is the service effective?

Inadequate

The service was not effective. The service had a high turnover of permanent staff and high usage of agency staff which meant that people did not receive consistent care from staff who knew their needs well.

Staff had not been adequately supported. They told us that they did not have access to all the training they needed and that, as a result, they did not feel confident in some areas of their practice. Staff told us that they had not had opportunities to discuss their training and development needs.

The provider had not always obtained people's consent to the care and treatment they received or consulted relevant others to ensure that decisions were made in people's best interests. Staff were not sufficiently aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

The premises had not been adapted to meet the needs of people living with dementia. There was no personal identification on bedroom doors. There was no evidence of colour coding, signage or visual aids to assist orientation.

Is the service caring?

Inadequate

The service was not caring. People told us that some staff were kind and helpful but that others were not. They said that the quality of care they received was dependent on the staff on duty.

People's care plans did not contain information about their personal histories, staff did not have an adequate knowledge of people's interests and knew little of their lives before they moved into the service.

People were not consulted about their care plans or involved in care plan reviews. When they had requested changes to their care, these changes had not been actioned.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive to people's individual needs. People's preferences about their care were not recorded and care plans did not explore people's interests.

Care plans were not reviewed regularly to ensure that they continued to reflect people's needs. In some cases, this meant that people did not receive the support they required.

People did not have sufficient opportunities to take part in activities or to engage with others. There were no organised activities on the day of our visit. Some people were left for long periods without opportunities to interact or engage with other people. This meant that people were at risk of social isolation.

Complaints were not managed or investigated appropriately. People who had complained told us that the response to their complaints had been unsatisfactory and that no improvements had been made as a result of their complaints.

Is the service well-led?

Inadequate 

The service was not well led. A culture had developed within which some staff felt bullied by others and refused to take instruction from their managers. Staff did not feel supported by effective leadership and were not confident that any concerns they raised would be dealt with effectively by management.

Staff and relatives told us that a small group of care workers were disruptive and displayed an inappropriate attitude to their work. They said that they had heard these staff refusing to carry out instructions given by their managers and using inappropriate language within earshot of people living at the service and their visitors.

The provider's quality monitoring system was not effective as concerns identified during our inspection had not been captured through monitoring visits. In addition, where the provider had identified shortfalls through the quality monitoring process, they had failed to take action to address these concerns.

The quality of recording was inadequate. Care documentation was not up to date and did not always reflect people's needs. Staff completed records retrospectively, which meant they could not be sure that the information they recorded was accurate.

Upper Halliford Nursing Home

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 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.

The inspection took place on 8 January 2015 and was unannounced.

The inspection was carried out by an inspector, a pharmacy inspector, a specialist nursing advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the evidence we had about the home. This included any notifications of significant events, including safeguarding referrals, which had occurred since the last inspection. We spoke with the local safeguarding authority and the local authority quality assurance team that monitored the service.

During the inspection we spoke with 14 people who lived at the service and six relatives. We also spoke with eight staff, including the two registered nurses on duty and the regional manager, who was in day-to-day charge of the service at the time of our visit. We observed how people were being cared for by staff. We looked at the care records of five people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at four staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

Our last inspection of the service took place on 28 May 2013, at which time the provider was meeting all the standards we assessed.

Inadequate

Is the service safe?

Our findings

People told us that there were not enough staff available to provide their care in a timely way. They told us that they often had to wait a considerable time for staff to attend if they rang their nurse call bells. One person told us that they preferred to get up by 9.00am each day but that there were not enough staff available to support them to do so. The person told us, "Sometimes they don't get me up till lunchtime."

Relatives told us that there were insufficient staff available to meet people's needs and keep them safe. One relative told us that they had arrived on several occasions to find their family member calling out for help and unable to locate a staff member to assist them. Relatives told us that when their family member used the nurse call bell, they routinely had to wait 20 minutes for staff to respond. One relative said, "We've had to wait 50 minutes for a carer when we've rung the bell to help mum go to the toilet."

We observed during our inspection that there were insufficient staff on duty to meet people's needs in a timely way. We heard one person calling for help from their bedroom. The person told us that they had activated the nurse call bell some time earlier but that they were still waiting for staff. We waited with the person for 10 minutes until a staff arrived. Throughout the day we noted that staff provided support in a task-oriented way as they did not have sufficient time to spend with people before moving on to another person who needed their help. Staff told us that there were not enough of them on duty on each shift to meet people's needs effectively. Care staff said that they often felt rushed when providing people's care and a nurse told us that the lack of available staff meant that they did not have time to keep people's care plans up to date.

We asked to see the assessment tool used by the provider to calculate the staffing levels needed to ensure that people's needs were met. We were advised that there was no specific assessment carried out to calculate the required staffing levels. This meant that the provider could not be assured that staffing levels were sufficient to meet people's needs and keep them safe.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not kept safe by the provider's recruitment procedures. The provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. The certificate returned to the provider by the DBS for one staff member recorded convictions for offences committed between 1980 and 2008, only one of which had been declared on the staff member's application form. There was no evidence that the provider had considered or assessed the risk to people posed by the employment of a member of staff with a significant criminal record.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were appropriate medicines protocols in place, we found that these were not always followed and that people's medicines were not always managed appropriately. A healthcare professional had prescribed one person with an anticoagulant medicine on 11 November 2014. They requested that nursing staff obtain the results of a further blood test in one week to ensure that the dose prescribed was appropriate. Nursing staff had failed to obtain the results of a second blood test as requested by the healthcare professional, which meant that the person was at risk of receiving an incorrect dose of medicine. Another person's medicines administration record indicated that their medicines had not been administered on 16 of the last required 56 doses. We identified a discrepancy in the recording of some medicines. The balance shown in the medicines record did not reconcile with the medicines in stock.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were appropriate arrangements for the ordering, disposal and storage of medicines. Records of medicines ordered, received, carried forward into the next cycle and disposed of were maintained. There were appropriate protocols and policies in relation to medicines management. This included checks and audits of medicine use, medicine administration records, temperature checks, daily medication patch check and medicine receipt records. There were documents for medicine use where the dosage instructions were different from the normal or varied on a daily basis. Care plans contained information for medicines to be administered only if needed and letters from the speech and language therapy (SALT) team about consistency of liquids to give to people.

People were at risk because staff did not have adequate knowledge of the equipment available for dealing with

Inadequate

Is the service safe?

medical emergencies or sufficient training to use the equipment effectively. We asked the nurse on duty on the ground floor unit what equipment was kept in the home for dealing with medical emergencies. The nurse told us, "A defibrillator, but there are no resuscitation masks as far as I know. We couldn't use it anyway as we have had no training." We found that resuscitation masks were available, stored in the clinical room. We asked the nurse on duty on the first floor unit what equipment was kept in the home for dealing with medical emergencies. The nurse told us that the home had a defibrillator but that it was not working. We asked the nurse why the defibrillator was not working and they replied that they did not know. We checked the defibrillator and found that there was no battery in the unit. The battery was in date and stored in a separate carrying case.

People were also at risk because some staff had not received up to date training in how to deal with medical emergencies. Three of the staff we spoke with told us that they had not attended First Aid training since they joined the service. The Regional Manager provided us with the staff training record for the service. The training record did not contain any evidence that staff had attended training in First Aid. The Regional Manager told us that the training course entitled Basic Life Support included elements of First Aid training. The training record indicated that only 20% of staff were up to date with their Basic Life Support training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were written procedures for safeguarding vulnerable adults and the staff we spoke with were aware of these. They were able to describe what they would do if they suspected someone was being abused or at risk of abuse. There was information about safeguarding adults on display for people living at the service, visitors and staff. The previous manager had reported allegations of abuse to the local safeguarding authority and the Care Quality Commission when necessary.

Inadequate

Is the service effective?

Our findings

People did not receive consistent care from staff who knew their needs well. The service had a high turnover of permanent staff and high usage of agency staff which meant that people did not receive their care from staff who knew their needs. The was compounded by the fact that staff did not keep people's care plans up to date to ensure that they continued to reflect their needs. New or agency staff referring to care plans could not be sure that the guidance accurately described their needs and the way in which they preferred their care to be provided.

Relatives told us that staff did not understand people's requirements. We were told that agency staff had twice offered one person oral fluids despite their care plan specifying that they should receive all their nutrition through a feeding tube. The relative told them that they had made a formal complaint to the provider following the first incident but that this had not prevented a repeat occurrence. Relatives reported that staff did know what adaptations and equipment their family members required. One relative said that staff consistently provided their family member's drinks in vessels that they were unable to use and another said that some staff were unaware that their family member used a hearing aid so did not remind them to use it.

Staff had not been adequately supported and had not received all the training they needed to carry out their roles effectively. The staff files we checked demonstrated that staff had received an induction when they started work but contained no evidence that staff had received regular one-to-one supervision with their managers. The staff we spoke with told us that they did not feel well supported through the supervision process. They said that they did not meet regularly with their managers or have opportunities to discuss their training and development needs.

Staff told us that they did not have access to all the training they needed. For example one of the nurses on duty told us that they did not understand the requirements of the Mental Capacity Act 2005 as they had not attended training in this area. Another member of staff told us that they did not feel confident in their moving and handling techniques as best practice guidance had changed since they last attended training in this area. Two staff told us that they had asked for training in some aspects of their roles as they did not feel sufficiently skilled in these areas, but that the training had not been provided.

The regional manager provided us with the training record for staff employed at the service. The record indicated that a significant proportion of staff were not up to date with their core skills training. For example more than half the staff team were not up to date with nutrition and hydration training and moving and handling training. The provider's own calculation showed that less than half of staff had received all their core training in areas such as nutrition and hydration and moving and handling.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans did not demonstrate that people had given their consent to the care and treatment they received or that, where they could not give consent, the provider had ensured that decisions were made in the person's best interests. Staff were not sufficiently aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA protects people who may lack capacity and ensures that their best interests are considered when decisions that affect them are made. The Deprivation of Liberty Safeguards ensure that people receive the care and treatment they need in the least restrictive manner. The training record indicated that almost half the staff team were not up to date with MCA training and there was no evidence that staff had attended training in relation to DoLS. Staff were not able to tell us whether any of the people they supported had had mental capacity assessments to determine their capacity to make decisions. The regional manager advised that no DoLS applications had been made to the local authority despite a number of people being identified as requiring these to ensure that their care and treatment was provided in the least restrictive manner.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises had not been adapted to meet the needs of people living with dementia. There was no personal identification on bedroom doors. There was no evidence of colour coding, signage or visual aids to assist orientation. In some cases, signage was confusing to people. For example

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Is the service effective?

a dining room had a sign on the door stating 'Activities' and a lounge on the ground floor had a sign on the door stating 'Dining Room.' There was a noticeboard in the lounge which aimed to assist orientation by displaying the date and day of the week. This had not been changed for two days, which meant it was confusing to people.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they liked the food at the home and that they could have alternatives to the menu if they wished. One person told us, "The food is good. I asked for a particular meal and they made it for me." We observed that people were able to choose what they wanted to eat for their lunchtime meal. Dining tables at lunchtime were attractively laid with white tablecloths, flowers and placemats. The atmosphere was relaxed and unhurried and we observed that people enjoyed their meals. People who needed help to eat their meals were supported by staff. Staff ensured that people who needed clothing protectors were given them. People who required soft diets were provided with these and the individual constituents of the meal were presented separately on their plates. Some people chose to eat their meals in their bedrooms and this decision was supported by staff.

Inadequate

Is the service caring?

Our findings

People told us that some of the staff who provided their care were kind and helpful but that others were not. They said that the quality of care they received was dependent on the staff on duty on each shift. One person told us, "Some [staff] are really good; they can't do enough for you, others leave a lot to be desired." Another person told us that they liked to go for a walk each day and that they required support from staff to do this. They said that some staff were happy to support them to take their walk but other staff routinely said they were too busy when asked for support.

Relatives told us that the quality of care their family members received was variable. They said that some staff were caring and sensitive to their family members' needs but that other staff were not attentive and did not appear motivated to provide good care. One relative told us, "Some of the carers are very good, they work really hard, but there are others who don't seem interested to be here."

We observed that some staff supported people in a kind and sensitive manner, ensuring their wellbeing and comfort when providing their care. These staff were proactive and positive in their interactions with people and spoke with people in a respectful way. They encouraged people to make choices and to maintain their independence. We observed that other staff did not engage appropriately with people while supporting them. For example one staff member supported a person to eat their lunch but did not make regular eye contact or converse with the person while supporting them.

Some relatives told us that their family members were not supported to maintain their appearance. They said that their family members sometimes appeared unwashed and that their teeth did not look as though they had been brushed. Relatives told us that they had raised their concerns about their family members' care with the previous manager but that no improvements had been made as a result of their complaints.

Staff on duty during our inspection did not always show concern for people's wellbeing in a caring way or respond to their needs quickly enough. We observed that three people sitting in the lounge needed support to wipe their noses but that this was not actioned by staff until we pointed it out to them. We observed that people who stayed in their rooms during the day were not supported to engage with others as staff did not visit their rooms to speak with them and check on their welfare. Some people living with dementia appeared confused and anxious at times but their anxieties were not addressed by staff.

The staff we spoke with did not have an adequate knowledge of people's interests or likes and dislikes. People's care plans did not contain information about their personal histories, which meant that the staff who supported them knew little of their lives before they moved into the service. For example care plans did not record details such as family life, education, employment or hobbies and interests.

People were not given sufficient opportunities to be involved in making decisions and planning their own care. The care plans we checked failed to demonstrate that people and their representatives were consulted when the care plan was first drawn up or in subsequent reviews. Relatives told us that when they or their family members had requested changes to the care they received, these changes had not been actioned. This meant that people's views about their care and treatment were not acted upon.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's individual needs. Care plans did not record people's interests or events in which they liked to participate and people were not supported to take part in meaningful activities.

People's needs had been assessed before they moved into the service but the care plans we checked had not been reviewed regularly to ensure that they continued to reflect people's needs. People told us that they were not asked for their preferences about how their care was provided. They said that they received their care from many different staff, some of whom did not know their needs or how they preferred their care to be delivered. Relatives told us that they had made staff aware of their family members' interests but that this had not resulted in opportunities for their family members to pursue these interests.

Some relatives told us that their family members' care plans did not accurately reflect their needs, which meant that they did not always receive the support they required. One relative told us that their family member's care plan stated that they could walk with a frame, which was not accurate, and that they had their own teeth when in fact they wore dentures.

We found that none of the care plans we looked at contained evidence of monthly review to ensure that they continued to reflect people's needs and wishes or of an annual review involving representatives of the person. For example one relative told us that their family member's care plan had not been updated to record that they now used a frame when walking. They said that their family member had been put at risk by staff encouraging them to walk without the frame they needed to support them. We asked one of the nurses on duty why people's care plans contained no evidence of regular review. The nurse told us, "We have no time to update care plans, we are too busy fighting fires."

People did not have sufficient opportunities to take part in activities or to engage with others. The service employed an activities co-ordinator but there were no organised activities on the day of our visit and no evidence of an activities programme. None of the people we spoke with could tell us any activities that had taken place recently or that were planned for the future. Relatives told us that activities were rarely organised in the communal areas and that most people sat in front of the television in the lounge. We were told that people were not supported to leave their bedrooms to take part in activities or to socialise. One relative said of their family member, "He gets no stimulation at all; he's just left in a chair all day." Another relative told us, "Mum's left in her room all the time. They don't put her in her wheelchair to go and join the activities." This meant that people were at risk of social isolation.

An activities co-ordinator was employed at the service but they were not present on the day of our inspection. Care staff did not organise any activities during our visit. People in communal areas were seated in front of the television for long periods with no other stimulation. People who stayed in their rooms were not visited by staff to engage them in meaningful activity. The activity board displayed in the home indicated that the activities available in the week of inspection were hair dressing on one day and pet therapy on another. We noted that the local authority quality monitoring team had also highlighted the absence of activities, reporting that during their quality monitoring visits, "There was no evidence of meaningful activities taking place."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place but people and their relatives told us that complaints were not managed appropriately. Three of the relatives we spoke with said that they had made complaints about the care their family member received but that no action had been taken to address their concerns. One relative told us that they were unhappy about an aspect of their family member's care and said, "I've complained about it twice but there's been no improvement at all." Another relative told us that they had complained about the quality of the records that staff maintained about their family member's care but that there had been no improvement in the quality of recording.

We checked the provider's complaints log and found that complaints were not always investigated thoroughly. Some complainants had received appropriate responses from the previous manager but others had not. In some cases, there was no evidence of appropriate investigation of the concerns raised or that the complainant had received a response. We also found that complaints were not always acted upon by the provider. For example one person had

Inadequate

Is the service responsive?

complained about care that had put their family member at risk. We found that subsequent complaints by the same person had been made because staff continued to provide care in a way that put their family member at risk.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

A culture had developed within which some staff bullied others and refused to take instruction from their managers. Staff told us that they did not feel supported by effective leadership or management. Some staff told us that they had concerns about the behaviour of colleagues but had not expressed these to their managers because they were not confident their concerns would be dealt with effectively.

A relative told us that, during their family member's respite stay at the service, "Some of the staff were shocking in their behaviour and attitude." Another relative told us that they had heard on several occasions care staff refusing to take instruction from nursing staff and the previous manager. The relative said, "They [staff] argue with one another and raise their voices to the nurses. We've often heard staff bickering amongst each other." The relative added, "There's a group of them that run things. There's nobody to keep them in order. The previous manager didn't have any control over them."

Just prior to the inspection, CQC received information alleging that some staff bullied and harassed their colleagues. The person raising the concerns told us that a minority of care workers routinely refused to follow instructions given to them by nurses or the manager. The person reported that they had raised their concerns with the provider but that their concerns had not been addressed.

Staff told us that a small group of care workers were disruptive and displayed an inappropriate attitude to their work. Staff reported that staff meetings were held but that they were not productive because staff often argued with one another. Two staff members told us that they had felt bullied by colleagues in the past. There was a whistleblowing policy in place but none of the staff we spoke with had used the policy to raise concerns. We discussed this with the regional manager, who advised that they had spoken to all staff to remind them of the need to use the whistle-blowing policy to report any concerns they had about bullying or poor practice.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in place at the time of our inspection. The previous registered manager had resigned in December 2014. The provider had not appointed a replacement manager but the regional manager advised that the process to recruit a new manager had begun. The regional manager was in day-to-day charge of the service at the time of our inspection.

There was a quality monitoring system in place and evidence that the provider carried out regular monitoring visits. However the quality monitoring system was not effective as concerns identified during our inspection had not been captured through monitoring visits. The monitoring visit report format used by the provider specified that a minimum of 10% of staff files should be checked at each monitoring visit. The monitoring visit reports for August, September, October and November 2014 had failed to check any staff files. The staff files we checked during our inspection revealed concerns about the provider's recruitment procedures which had not been identified by the provider's internal monitoring.

In some cases, the provider had identified shortfalls through the quality monitoring process but had failed to take action to address these concerns. For example the monitoring visit report for August 2014 stated, "The care plans are not true and accurate information of what the care needs are." Subsequent monitoring visit reports continued to identify inadequate care documentation as a concern and noted that, "The manager is not auditing care plans." At the time of our inspection the quality of care plans remained inadequate, which meant that the concerns initially identified by the provider five months earlier had not been addressed.

Prior to the inspection two relatives contacted CQC to raise concerns about poor record keeping. The relatives told us that they had witnessed staff completing their family member's care records retrospectively. One relative said "They [staff] fill in all the records at the end of the day." Both relatives told us that they had seen different versions of daily care records covering the same period but differing in their details of the care that had been provided.

During the inspection another relative told us that staff recorded care that had not been provided. The relative said that their family member needed to be checked by staff every 30 minutes throughout the day and night. The relative told us that on several of their visits no staff had come to their family member's bedroom to check on them but that staff recorded that they had made the checks. The relative told us that no checks had been made during their

Inadequate

Is the service well-led?

visits of 6 and 7 January 2015 but that staff had recorded that checks had been carried out. With the person's permission we checked their care records for these dates and found that staff had recorded checks every 30 minutes throughout the day.

We observed staff completing care records retrospectively. We checked the food and fluid records of one person who received their nutrition through a feeding tube. The food/fluid chart specified that the person's food and fluid intake should be recorded at hourly intervals throughout the day. We checked this chart at 1.30pm and found that the last entry had been made by staff at 8.00am. As we were checking the chart, a nurse entered the room and asked for the chart so that they could record the person's food and fluid intake. We watched the nurse retrospectively record the person's food and fluid intake for 9.00am, 10.00am, 11.00am, 12.00pm and 1.00pm. This meant that the nurse could not have been sure the information they recorded was accurate.

Staff did not always maintain records to ensure that people's healthcare needs were met. We found no evidence that staff recorded checks on the skin and feet of one person who had type one diabetes. The provider's policy on diabetes care states that people with diabetes should have their skin and feet examined weekly for any reduction in sensation or discolouration.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at all times to safeguard people's health, safety and welfare. The registered person had failed to ensure that staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had failed to operate effective recruitment procedures in order to ensure that staff appointed were of good character and suitable for the work to be performed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to protect people against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had failed to obtain people's consent in relation to their care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had failed to ensure that people living with dementia received their care in premises that had been suitably adapted to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had failed to operate an effective system for handling and responding appropriately to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to implement an effective system to monitor the quality and safety of the services provided and to maintain accurate and complete records in respect of the care provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had failed to provide care and treatment that met people's needs and reflected their preferences.