Care Quality Commission

Care UK Community Partnerships Limited

The Potteries

Inspection report

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Date of inspection visit: 10,11,12 & 18 March 2015
Date of publication: 05/06/2015

Ratings

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

Overall summary

This was an unannounced comprehensive inspection carried out on 10,11,12 and 18 March 2015.

The Potteries is a purpose built home which opened in October 2013 and is registered to accommodate a maximum of 80 people who require either nursing or personal care. There were 65 people living there at the time of our inspection. The home provides care for people living with dementia. One of the units provides nursing care. The home is well equipped and has good communal facilities which include a café, cinema and hairdressing salon.

There was no registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

The home was being led by an acting manager who had been in post since February 2015. The post was being advertised and applicants selected for interview at the time of our inspection.

The Potteries has experienced a long period of instability due to frequent changes in the temporary management arrangements during the long term absence of the

Summary of findings

previous registered manager. The home was newly opened at the start of the registered manager's absence and was not fully operational. A local care home closed and almost all of the people living in that home moved to The Potteries within a very short space of time. This meant that new staff had to be recruited and trained whilst getting to know a large number of people, the majority of whom had complex needs because they were living with dementia. Staff recruitment took a long time and home needed to rely on temporary agency staff. Most of the people who took on the role of home manager did not have previous experience of managing a residential care service and did not have a full understanding of the the providers' systems, policies and procedures. This meant that policies, procedures and systems that Care UK has developed to ensure that people were cared for safely, effectively, responsively, in a caring manner, and that the service was well led had not been fully implemented.

At our last inspection in July 2014 we found breaches in the regulations relating to the care and welfare of people who use the service and record keeping. Registered providers are required to send us an action plan setting out how they will comply with any breaches in regulation. We did not receive an action plan from the provider in relation to these breaches.

At this inspection we found that there were further breaches in these regulations and additional regulations relating to assessing and monitoring the quality of service, management of medicines, respecting and involving service users and making notifications to the Care Quality Commission.

People's medicines were not managed safely. Medicines were not stored, administered and recorded safely. This meant that there was a risk that people may not receive their medicines as prescribed. Staff were not working in accordance with the training they had been given, company policies and national guidance including the Nursing and Midwifery Council's (NMC) guidelines for registered nurses. People were at risk of not receiving the correct medicine, in the correct quantity and at the correct time.

Peoples health and care needs were not always fully assessed and planned for in a way that would protect them from risk and ensure their needs were fully met. Changes in need were not always recognised and reviewed. People were at risk of not receiving the support they required to meet their personal care needs. For example, two people had not had their needs assessed more than a week after their admission to the home. One of these people was receiving end of life care, and the other person needed help to mobilise and unable to communicate.

People were not always supported to eat and drink enough to meet their needs whilst promoting their dignity and independence. One person had not been provided with adapted cutlery and a plate guard to help them eat. Due to the difficulties they experienced, this person used their fingers to feed themselves. Another person, who was being cared for in bed, had their meal left in front of them for more than two hours even though they were unable to eat it without support.

Staffing levels were calculated by looking at the number of people in the home and their level of need. This was satisfactory. However insufficient information had been obtained prior to some staff being employed to ensure that they were suitable for their role. Staff training and supervision was out of date but the acting manager had put a plan in place to address this.

Staff were caring and treated people kindly. People were positive about the care and support they received from staff. One person told us "I like it very much here. It's nice and clean and the people are very nice and very friendly." However staff did not always demonstrate that they had the skills to promote people's right to independence, dignity and choice. For example, some people were not offered a choice of meals because staff had not obtained photographs of meals which were available to other people living on other units in the home.

A comprehensive range of activities and events was provided seven days a week by activities coordinators and care staff. During our inspection there were coffee mornings, visiting dancers and musicians, craft activities and quizzes.

The provider had failed to notify CQC when Deprivation of Liberty applications had been made.

Record keeping in the home was poorly organised. We found concerns with care documentation, medication records, food and fluid charts, repositioning charts and creams administration records.

Summary of findings

There were quality monitoring and audit procedures in place which had identified many of the shortfalls found during this inspection but action had not been taken to address these concerns.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use the service (and others where appropriate). When we propose to take enforcement action our decision is open to challenge by the provider through a variety of internal and external processes. We will publish a further report on any action we take.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Systems for the management of medicines were unsafe and did not protect people.

Care was not always planned and delivered in a way which protected people from the risk of harm.

Staffing levels were satisfactory and there were procedures in place to safeguard people from abuse. There was limited evidence of the satisfactory conduct or good character of staff in their previous employment

Inadequate

Is the service effective?
The service was not effective.

People's needs were not assessed and planned for promptly on admission to the home or when their needs changed.

Some people may not have been receiving the drinks they needed to prevent them from becoming dehydrated. People were not always supported to eat and drink enough to meet their needs.

Inadequate

Is the service caring?
The service was caring but some improvements were needed.

Staff were kind and caring and people were positive about the care they received.

Staff did not always demonstrate that they had the skills and knowledge to promote people's rights to independence, dignity and choice.

Staff were not always aware of people's life histories and the importance of using this information when providing care and support.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were at risk of receiving unsafe care because their care plans were not always followed, changes in needs were not always reassessed and planned for and contradictory instructions were not identified and questioned.

People's need to be meaningfully occupied and stimulated was met.

The service had a complaints policy and complaints were responded to appropriately.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The Potteries had been without strong stable management for a sustained period of time. The aims and objectives of the provider had not been delivered.

Quality monitoring and audit procedures had identified many shortfalls but action had not been taken to address the concerns.

Record keeping was poorly organised and we found many inaccuracies, inconsistencies and contradictions in the records we reviewed.

The home had an open culture and staff told us that they felt able to raise concerns.

The Potteries

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 checked 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 10, 11, 12 and 18 March 2015 and was unannounced. There was a lead inspector present throughout the inspection, a specialist advisor and additional inspector for two days and an expert by experience for one of the days. We spoke with and met 14 people living in the home and eight relatives. Because some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We reviewed the information about the service along with other information we held about the home which included notifications they service is required to make. We also contacted one commissioner and seven health care professionals involved with people to obtain their views.

We looked at 13 people's care and support records, an additional five people's care monitoring records and medication administration records and documents about how the service was managed. This included staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with during our inspection of The Potteries told us they felt safe. We also spoke with a number of visitors who confirmed that they believed that The Potteries was a safe place for their relative or friend to live. One person told us about the care their relative had received in another setting and could not speak highly enough of the way The Potteries had improved their relative's life since moving to the home.

However, we found that appropriate steps had not always been taken to keep people safe and to identify, assess and manage risk.

Staff training records showed that all staff who were authorised to administer medicine had undertaken refresher training and a competency assessment within the last twelve months. The provider had carried out a medicines audit that identified a number of issues which were addressed with staff through supervision and training. Since then, we saw that staff were given a tool to carry out weekly audits to ensure medicines were being managed appropriately. We identified a number of concerns regarding medicines than had not been highlighted through the weekly audit process. These concerns also evidenced that staff were not working in accordance with the training they had received, company policies and, in the case of the registered nurses, in accordance with the Nursing and Midwifery Council's (NMC), guidelines on medicines.

On the first day of the inspection we found that the breakfast medication round for people living on the nursing unit was still in progress at 11.30 am although breakfast medications were prescribed to be given at 8.00 am. This meant that people were receiving their medication much later than it had been prescribed. In addition, we noted that the medication administration record showed that the medications had been given at 8.00am and the correct time of administration had not been recorded.

One registered nurse was dispensing medication into individual pots and handing it to another registered nurse to take to the person. The first nurse was signing the record to say that the medication had been administered although they did not witness this take place.

The provider's medication policy stated: "The person preparing the medicines MUST be the same person who administers the medicines or observes the medicines being taken and must go directly to the resident to administer the medication" This meant that the registered nurse was not following company policy or national good practice guidelines for the safe administration of medicine.

The lunchtime medicine round was scheduled to take place at 1.00pm. We saw that the registered nurse commenced administering medicines at this time and did not take into account that people had only received their 8.00am medicines a short time before. This meant that there was a possibility that people could receive medicine too quickly after the previous dose was given.

We checked the controlled drugs register on two of the three floors of the home. On the nursing unit, we noted that there were some discrepancies. Two different people had entries for medicines where the record made was incorrect and therefore the running total in the record did not correspond with the actual quantity of medication in stock. This meant that it appeared that a considerable quantity of a controlled drug was unaccounted for. The record had been signed by the member of staff that wrote it and counter signed by another member of staff to confirm that they had checked the record and the stock and it was correct. The staff had not detected the error and the weekly audit had also not identified the error. In addition, we noted that there were some entries in the controlled drug register that did not have a witness signature.

We checked the stock of another controlled drug. We found that the register stated that there should be 190mls of medicine in stock but that there were only 100mls in the controlled drug cupboard. We spoke with the registered nurse who told us they thought that the missing quantity had been destroyed because it was out of date. However, there were no records to support this. The clinical manager and acting manager responded to this immediately and were able to establish that the medication had been destroyed but the registered nurses concerned had failed to record this.

Many of the people living in the home had been prescribed creams to relieve various skin conditions. We found instances where the pharmacy prescription label, the care plan and the medication administration records for creams contradicted one another with regards to the frequency of application.

Inadequate

Is the service safe?

Staff confirmed that they followed the instructions for administration on the prescribed cream recording chart which also provided a body map to show where the cream should be applied. We found that there were gaps and errors in all of the charts that we checked. For example, the instruction on the dispensing label was that a cream should be applied three times a day. The instruction on the creams recording chart was twice a day and entries to confirm when creams had been applied were sometimes only once and day and there were gaps in the recording where no record of application had been made for a 24 hour period or more. Staff told us that there were also computerised records and they thought that sometimes people recorded in the computerised system that creams had been administered. We checked this for some of the errors and omissions that we found and there were no entries on the computer system. This means that people cannot be sure that they were receiving their prescribed creams correctly.

Also during our check of the medication administration systems on the nursing unit we found that a number of medication administration records contained gaps with no explanation or code to confirm why a medicine had not been given. Some medicines had been altered during the period of the medication administration record. Alterations had been made to reflect the change in dosage, time or frequency but these had not been signed and dated and there was no witness signature. During the second day of our inspection, we found that one of the people living on the nursing unit had been admitted to hospital the previous evening. Although the person was not in the home, the registered nurses had signed the medication administration record to confirm that they had given the person their medication.

We found the provider had not protected people against the risks associated with the unsafe use and management of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to manage risk. The provider had developed risk assessments for people's needs and these included pressure areas, nutrition, falls, moving and handling and other specific conditions such as diabetes, urinary tract infections and behaviour that challenges. The assessments identified the risk and prompted the assessor to take action to reduce or manage the risk. However, we found that two people had been living in the home for more than two weeks and no risk assessments had been carried out. This meant that the provider had not taken action to identify, assess or manage any risks relating to their care.

The provider had not taken proper steps to ensure that people were protected from the risk of receiving care or treatment that is unsafe or inappropriate. This was a repeated breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at six staff recruitment records and spoke with two staff about their recruitment. Within each staff file we found proof of identity including a recent photograph and a satisfactory check from the Disclosure and Barring Service. (Previously known as a Criminal Records Bureau check).

We found that there was limited evidence of satisfactory conduct in previous employment or good character. This was because in three of the six staff files that were examined, references had been provided by colleagues rather than their employer or line manager and testimonials had been accepted. That is, a letter written to no specific person by a referee about the general qualities of the person and not specific to the job that the person applied for. All of the staff without satisfactory references were shown on the rota as already working with vulnerable people.

The provider had not taken proper steps to ensure appropriate checks were undertaken before staff began work with people. This was a breach of the Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager explained that the number of staff on each unit was dependent on the number of people living on the unit. Staffing levels could be further increased if people's needs meant that a higher ratio of staff was needed. During the course of the inspection we spoke with a number of staff who confirmed that, for the most part, staffing levels were sufficient to keep people safe and meet their needs.

Inadequate

Is the service safe?

There were safeguarding adults policies and procedures in place. We spoke with four staff who confirmed that they had undertaken training and understood what constituted abuse. They were able to describe possible signs that a person had been abused and tell us how they would report any concerns or allegations. There was information on notice boards around the home about how people and staff could report any allegations of abuse. Records showed that safeguarding alerts had been made to the local authority when any concerns were raised.

Environmental risks within the home were managed safely. There were risks assessments for each part of the home and also for the various systems such as for the heating, hot water, electricity and gas supplies. There were also comprehensive maintenance records for each part of the building as well as servicing contracts for all equipment and the fire prevention systems. The records were up to date and risk assessments had been reviewed regularly. Records showed that other health and safety checks such as the testing of the water system for legionella, hot water temperatures and portable electric appliance testing were all undertaken.

Is the service effective?

Our findings

People's health needs were not consistently met. People and relatives told us that medical attention was sought promptly but this was not supported by some of the findings from the inspection.

One person had unstable diabetes. The acting manager took the decision to move the person to the nursing floor of the home to provide better support for the person. The care plan that had been created following the move to the nursing floor did not identify that the person had unstable diabetes, gave insufficient detail about how to manage their diabetes and did not detail possible risks or complications or that a health professional had been consulted.

Two people had been admitted to the home over two weeks before the inspection. We found that no assessments or care plans had been created to ensure that the home understood all of their needs and had a plan to ensure that their needs were met. One of these people had been admitted with wounds but there was no assessment of these or treatment plan. There was a photograph of a large bruise to the person's shin that was dated after their admission to the home. There was no measurement or scale shown on the photograph and no information about how the injury had occurred.

A number of people had wounds that required care. We found that all of the information about wounds was kept in one file and not in people's personal care records. The file indicated the dressings to be used but there were no care plans in place to explain how the wounds were to be managed, the frequency that the wounds should be checked and re-dressed or evidence of whether the wound was healing.

A number of people had pressure relieving mattresses on their beds either to prevent pressure sores or to help treat them. We found that one of these mattresses had the incorrect setting. This meant that the person may not be receiving the optimum benefit from this equipment. This was noted on the first day of the inspection and pointed out to staff. We found that the mattress was still on the wrong setting on the last day of the inspection. The provider has mattress checking system in place. The records for this mattress stated that it was set correctly and had been signed as such by staff for both the days we found it to be incorrect and the days in between.

The provider had not taken proper steps to ensure the welfare and safety of people using the service. This was a repeated breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to a number of staff about people's needs and how they met them. They told us that they had training available to them to ensure that they understood how to provide good care. Staff also told us that they had received comprehensive induction training when they first started their employment at The Potteries and that this had given them the necessary basic skills they required.

Analysis of staff training records showed that some staff had not completed annual refresher training in essential areas such as safeguarding adults, infection prevention and control, moving and handling and fire prevention. The acting manager was able to demonstrate that they were aware of this and had made additional hours available to staff to enable them to undertake their training.

Staff told us that they felt well supported by the acting manager, unit managers and senior carers. They acknowledged that the home had experienced a lot of management changes in the previous 12 months and that this had meant that they had not always felt well supported but were hoping that the management of the home would soon be stabilised. Records of supervision and appraisal showed that a number of staff had not received formal supervision for some time. The acting manager showed us that a plan had been drawn up to ensure that all staff received regular supervision in the future.

Staff told us that the home provided a cooked breakfast and choice of cereals, toast and other items for breakfast, a three course lunch with choices for each course and an evening meal that also had a number of choices. We were told that drinks and snacks were available at all times. There was also a small café with a drinks machine which provided tea, coffee and hot chocolate and a selection of homemade cakes. During the inspection we saw a number of people come to the café to get hot drinks either with staff or with visitors and the area worked very well as a social

Is the service effective?

hub. We observed staff on the two residential units discussing menu options with people and trying to help them make a decision. They had photographs of meals to help people as well as lists of people's likes and dislikes to help them make a choice on people's behalf if necessary.

We observed the meal times in all three of the units in the home. Staff served meals to people individually and adjusted portion sizes either due to people's requests or because they knew how much each person was likely to eat. The meals we saw smelled appetising and looked attractive. All of the people we spoke with told us that they enjoyed the meals.

On the two residential units we saw that there was a relaxed and friendly atmosphere with plenty of interaction between people and staff which was friendly and caring. Some people did not seem to like the meals they were served and staff tried hard to find food that people did like. We saw that staff served meals to people from a list of names rather than by table order. This meant that some people on a table had to watch one person eat and that this person finished a long time before the others and had to wait a long time at the table. We saw one person waiting for their meal for nearly 10 minutes while the other person on the table was eating theirs. The person kept calling to the staff as they were hungry and found it hard to watch the other person eat. We looked at incident records for the unit and saw that there had previously been altercations between people over food.

The provider was monitoring the fluid intake of some people because they were assessed as being at risk of dehydration. We checked a number of fluid charts. Many of them did not record a target amount of fluid and this meant that staff could not recognise whether their total intake over a 24 hour period was sufficient. Analysis of fluid intake for three people over the previous seven days showed that one person had received 58% of their target fluid intake, another 59% and another 61%. There was no information in care plans about what to do if people failed to take sufficient fluid and there were no entries in daily records about any action that had been taken to encourage people to increase their fluids. Staff told us that this was discussed at handover. We saw a member of staff completing a drinks round. They recorded the amount they had given to the person and not the amount that was consumed. This meant that the records may not provide an accurate reflection of the amount that people had drunk.

Meal times on the nursing unit were quiet with very little interaction between people and staff. Staff chatted amongst themselves and discussed tasks that needed to be completed. The meal had started being served at midday. People were still eating their lunch at 1.30pm Staff told us that they found meal times one of the most difficult times because so many people needed support to eat and drink. They said that this problem was exacerbated because staffing numbers dropped by one person at 1pm and other staff took their lunch breaks over the same lunch period as meals were served to people in the home.

We met a visitor who was helping someone to eat their lunch at 2.30pm They told us that staff put the meal in front of their relative at 12.30pm but do not cut their food up or provide any help for the person to eat their meal. The visitor told us that they frequently have to help the person to eat their meal when they arrive at 2.30pm by which time the food is cold and the person has spent two hours looking at the food without being able to eat it. The visitor told us that they had discussed this with staff and asked for food to be reheated but no changes had been made.

We saw one person trying to feed themselves. They had not been provided with adapted cutlery and a plate guard to help them eat. The person used their fingers to feed themselves. Staff were sitting at the same table as this person and took no action to support them.

The provider had not taken proper steps to ensure that people were protected from the risk of inadequate nutrition and hydration. This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Applications had been submitted to the local authority for a number of people and the home were waiting for assessments to be carried out. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards

Is the service effective?

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found mental capacity assessments and best interests decision making records in people's individual care records to support this as well as discussing the processes involved with some of the staff.

The home opened in 2013 and was purpose built to accommodate older people, including people who live with dementia. There was level access to secure garden areas from the ground floor. Bedrooms and communal areas were spacious and people were able to bring their own furniture and possessions to personalise their rooms if they wished. Signage was not clearly adapted to assist people living with dementia: toilets and bathrooms were not identified other than with small written signs and a small photograph.

Is the service caring?

Our findings

All of the people that we spoke with during the inspection were positive about the care they received and their relationships with the staff. Relatives and other visitors were also mostly positive about the care and accommodation at The Potteries. One person told us "It's the staff who make the difference, they are interested in my Mum and have made the effort to get to know her as a person". Another person told us "They are good at keeping us informed about any issues and call the GP if necessary. They have tried really hard to get Dad to join in with the activities".

Some people living on the nursing unit found it difficult to communicate and needed support to eat and drink. We asked staff how people were encouraged to make a choice for their meals. Staff told us that they relied on what they knew of people and made decisions for them. We asked if they had other methods of trying to help people make a choice, such as the photographs that were used in the other units. Staff told us that these were not available although we saw them in use in other units of the home. During afternoon tea we saw a trolley brought to lounge which had various different cakes and biscuits on it all of which looked very appetising. People were not given the opportunity to choose which item they would like as staff made a selection and gave it to them.

Staff told us that, wherever possible, they tried to involve the person in creating their own care plans so that they fully reflected how they would like to receive care and support. We found that this was inconsistent within the different units of the home. There were varying standards with regard to how people had been consulted and involved in their care plans and how their life histories had been included to inform staff about who they had been and what was important to them. Some visitors told us they were always involved in care plan reviews, especially if the person themselves was unable to contribute while others were not aware that care plans were in place. We found that some care plans, especially on the nursing unit, were more focussed on the task that was to be undertaken and did not detail how this should be personalised to the individual to reflect their likes and dislikes or how to obtain the most positive outcome for them.

We also found this to be the case with regard to care plans for people's end of life care wishes. Two sets of care plans contained contradictory information about whether people wished to be resuscitated and did not contain official Do Not Attempt Resuscitation records. There was also little or no information about people's social, cultural or religious needs either during their time living in the home or their preferences with regard to their end of life wishes.

We spent time observing people in one of the nursing lounges during one of the afternoons of the inspection. There were five people seated around the room and the television was on. Only two of the five people were positioned so that they could watch the television if they so wished and the volume was very low so may have been difficult for anyone in the room to listen to. For the first 15 minutes of the observation, no staff came into the lounge or made any attempt to interact with people or check on them. This was despite the fact that the lounge was on a corner part of the corridor and was semi open plan. We saw staff walk past in the corridor seven times but nobody came into the lounge to check on people. During this time one of the people sneezed repeatedly and then had to sniff because they had no handkerchief and no means of attracting staff attention.

The provider had not taken proper steps to ensure that people were involved in decisions about their care treatment and support and their rights to privacy, dignity and independence were respected. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the time we spent in the other units of the home we saw that staff sought to promote people's independence, privacy and dignity. Staff treated people with respect and took time to explain things to people such as the food that was being served or the activity that was being undertaken.

We saw that ancilliary staff including cleaners, catering staff, laundry staff and office and maintenance staff knew people's names and took time to greet them and chat with them.

Visitors that we spoke with told us that they were always made welcome and often invited to various special occasions in the home such as Red Nose Day fundraising and Mother's Day.

Is the service responsive?

Our findings

Our observations on the residential units and during activities in the communal areas showed us that people living in the home had good relationships with staff. Staff also were aware of people's life history, family and friends and interests. We saw one person become upset during an activity. Staff quickly sat with them, reassured them and led a conversation round to the person's children and grandchildren. The person quickly became settled and was soon happy and rejoined the activity.

People's care needs were not consistently met. Discussions with the staff and analysis of records revealed that some people had not received assistance with bathing, showering and hairwashing for long periods of time. We looked at people's care plans. Records showed that the people concerned lacked the capacity to understand the need for personal hygiene and, in many cases, a mental capacity assessment and best interests' decision had been made that staff should support people with these tasks. However, this did not seem to have been effectively communicated as records mostly stated that people had been "independent" with personal care or that night staff were to undertake the task. We discussed this with senior staff. They told us that people should have been supported to ensure that all areas of their personal care were properly met and records should reflect this. We tracked a number of records, both paper and computerised, and found that, in some instances, a number of weeks had elapsed between entries that staff had assisted people and also that, where night staff were allocated to the task, there was no evidence that this had been done. Having looked at as many records as possible and discussed the situation with care staff and senior care staff, they agreed that it was likely that their systems had failed and people had not received the care that they required.

Care plans were created following an initial assessment of people's needs before they moved into the home. The provider's policy stated that care plans should be reviewed on a monthly basis or if a change in need occurred. The majority of the care plans that we looked at were up to date. However, people did not always receive the support that was detailed in the care plans or care plans lacked sufficient detail for staff to be able to follow them and provide the care that people required. This was evident with regard to the provision of support for washing, bathing and showering. In addition, we found a care plan to manage a person's continence needs that did not reflect that they had had a catheter fitted some time previously and there was no information for staff about how to manage this, use of different bags for night and day, recording of output or what to do if any problems occurred.

Risk assessments had been undertaken with regard to the management of pressure areas. Those people who were identified as being at risk, had care plans which stated the equipment to be used such as special mattresses and cushions and how often people should be assisted to change position. We checked repositioning records for three people. We found that in all three cases, the frequency of position change that was stated in the care plan was different to the frequency that was the instructed on the repositioning records. For example, the care plan stated that a person's position should be changed every two hours and the repositioning record stated that it should be every three hours. In addition, the records of the actual times that staff had assisted people to change position showed that there were longer gaps between position change than either the care plan or the chart instructed. This meant that people were not receiving the care required to either prevent pressure sores or to aid the healing of any wounds.

The provider had not taken proper steps to ensure that people received the care, treatment and support they required to meet their needs. This was a repeated breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Potteries employs activities staff in addition to the care staff and there was a programme of activities each morning and afternoon from Monday to Sunday. All of the activities that took place during the course of the inspection were well attended and we saw people taking pleasure in joining in with whatever was taking place. Discussions with the activities staff showed us that they had managed to get to know people as individuals and understood how to motivate people and make them feel included. Everyone responded well to the activities staff and enjoyed the conversations and banter that they were having with one another. A number of people were taking part in a craft activity during one of our observations. One person told us "I didn't want to do this but I am glad I had a go".

Is the service responsive?

Information about how to make a complaint was displayed around the home. The acting manager also told us that information about how to complain was included in the information/welcome pack that was given to people when they moved into the home. We checked the records for three complaints that had been received. There was information about how the complaint was investigated, the outcome of the investigation and any action that was taken as a result of the complaint. We were told that there were also regular resident and relatives meetings to encourage people to make suggestions and raise any concerns.

Is the service well-led?

Our findings

The Potteries had been through a long period of instability due to frequent changes in the temporary management arrangements during the long term absence of the registered manager and for the home.

All of the people, relatives and staff we spoke with during the inspection spoke positively of the current acting manager. The acting manager had already identified some shortfalls, such as with regard to staff training and supervision and put plans in place to address these areas.

The provider had systems in place for regular auditing of the home and these included monthly visits from a regional director from the company as well as audits carried out by the acting manager. In addition, a Regulatory Governance Audit had been carried out by a company governance manager in November 2014. Many of the issues that have been highlighted in this inspection had already been identified through the provider's own systems. However the quality assurance process was not effective as the provider had failed to address the concerns that were identified.

In addition, an inspection carried out by the Care Quality Commission in July 2014 had highlighted breaches of the regulations relating to the care and welfare of people who use services and records. The provider did not submit an action plan to tell us how they would rectify the concerns, as is required by law. The provider had not taken action to address these breaches, and further breaches of the regulations have been highlighted at this inspection.

The provider had not used the findings from audits and inspections to protect people from risks of inappropriate or unsafe care. This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Record keeping in the home was poorly organised. People's personal records contained inaccuracies, inconsistencies and contradictions. The shortfalls in record keeping had implications for people's care and welfare. We found concerns with care planning, medication records, food and fluid charts, repositioning charts and creams administration records. Some records included contradictory information, for example the care plan for one person indicated that they had an allergy to a medicine, but the medication administration record stated that that the person had no allergies. There were two record keeping systems in the home: one was computerised and the other paper based. Staff told us that they were uncertain what they should record and where they should record it. Many staff told us that they found the systems cumbersome and that they spent too much time struggling to record things instead of providing care and support to people. When we asked them about the omissions in recording they said they felt that staff either did not know they should record things or assumed that others were recording it.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate records were not maintained. This was a breach of the Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had been made to CQC for the majority of the incidents. However, no notifications had been made to us for any applications under the Deprivation of Liberty Safeguards or the outcome of applications. The acting manager told us they had not been made aware of the requirement to do this.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010 because the provider had not notified the commission of incidents affecting people.

Observations and feedback from the people living in the home, relatives, visitors and staff showed us that the home has an open, positive and caring culture. The provider had carried out regular resident and relative's satisfaction surveys and held regular meetings in the home. The surveys had highlighted some areas for improvement and a plan had been developed to address these areas. For example, people had asked for more activities to take place outside of the home. The activities manager had drawn up a programme of events which included walks to a nearby park and trips out in a minibus. All of the visitors that we spoke with felt that the staff in the home communicated well with them and kept them reassured about the care their relative was receiving.

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 17 HSCA (RA) Regulations 2014 Good governance People who used services were not protected from unsafe or inappropriate care because the provider did not take action to improve the service when shortfalls were identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not taken proper steps to ensure each service user received was protected from the risk of inadequate nutrition or hydration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not involved, so far as they are able to do so, in making decisions about their care, treatment and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified the Commission of incidents affecting people.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Appropriate checks were not undertaken before staff began work.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not taken proper steps to ensure each service user received care that was appropriate and safe.

The enforcement action we took:
We have served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not protected service users against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
We have served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that people were protected from the risks of unsafe or inappropriate care because they had not maintained accurate records.

The enforcement action we took:
We have served a warning notice.