Anchor Trust

Birchlands

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 May 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the cleanliness and infection control, the management of people's medicines, safeguarding people from abuse, staffing levels, the need for consent, treating people with dignity and respect, care and treatment, assessing and monitoring the quality of the service, the accuracy of their records, how people were cared for and respected and requirements that related to the recruitment of staff.

We undertook this inspection to check that the provider had followed their plan and to confirm that they had now met legal requirements. This report covers our findings in relation to those requirements and any other additional areas that we looked at on the day of the inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Birchlands on our website at www.cqc.org.uk.

Birchlands is a purpose-built care home providing accommodation and personal care for up to 52 older

Summary of findings

people, some of whom are living with dementia. There were 46 people living at the home at the time of our inspection. Accommodation is arranged in seven units over two storeys.

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 manager had been in post for several weeks at the time of our visit and have submitted their applicationfor registered manager with the CQC.

The provider had not followed their plan of action and continued to breach legal requirements.

Sufficient improvements to how medicines were administered had not been made. Topical creams for people had not been given to people as prescribed. There were no gaps or discrepancies in the medicine charts for people. All medicine was stored and disposed of safely.

People were still at risk of harm. People were still at risk of falling as there were not enough staff to meet people's needs safely. People were being left on their own for long periods of time. Since the inspection in May 2015 there had been more falls. Risk assessments in people's care plans had not all been reviewed since the inspection in May 2015. One health care professional told us "They (the service) lack people on the ground, the busiest time is in the morning."

Staff practice led to some people being inappropriately restrained. One person was unable to get up from their chair as it was pushed in too much at the table.

There was no evidence that Mental Capacity Act 2005 (MCA) assessments had taken place in relation to whether people were able to consent to decisions being made. No additional Deprivation of Liberties Safeguards (DoLs) applications had been made to the local authority where needed. Additional training had not been provided to staff to increase their knowledge of MCA or DoLS since the last inspection.

Staff did not always provide the most effective care. Staff were not always provided with the most up to date information about the needs of the people they were caring for. They were not always provided with training around the conditions that people were living with.

Staff told us that before they started to work at the service they needed to complete the service's mandatory training including moving and handling and infection control and the records confirmed this.

People were not always supported to eat and drink sufficient amounts to maintain their health. People were positive about the quality of the food. One person said "It (the meal) was very nice."

We saw that the unit's design of the environment of the service did not help people with dementia to be as independent as they could be.

People had access to a range of health care professionals, such as the community nursing team, and the GP.

People said that staff were caring. One person said "I like it here, the staff are very kind" and another said "They (staff) are very caring and very helpful

We found that staff were not always as kind as caring as they could be. Staff did not always offer support or give people choices about what they wanted to do. People were left on their own for long periods of time without any interactions with staff.

We did see some examples of laughter and chatting between staff and people and we saw that people enjoyed that.

People's family and friends were able to visit at any time and we saw this happening throughout the visit.

People had their privacy and independence respected by staff. We saw people choose to sit in their rooms if they wished and heard staff knock on their doors before they entered.

There were not enough meaningful or individualised things for people to do on each unit. We did not always see staff encourage people to access any activities on the unit other than the radio being played or the television being on.

Summary of findings

There were some activities taking place in one of the large lounges on the ground floor that four people attended. We saw people enjoyed these and were happy to take part.

Care was not provided in response to people's needs. One person was at risk of pressure sores and steps had not been taken to reduce the risk of these developing whilst the person was sat in their chair.

Staff did not always have information about people's backgrounds. There was not always information in care plans around people's life histories and their preferences.

Comments from people about how caring the staff were varied.Comments included "I feel that I am being a nuisance if I want anything" and "I don't feel wanted (here)". One person said "I like it here, the staff are very kind."

One health care professional told us that the television was not always showing age appropriate programmes and felt that no one was asked what they wanted to watch. We also found this during our inspection. We did see that some people's care plans had been reviewed since the last inspection and that these reflected the person's up to date needs.

There were still gaps in the records around the care that had been provided. Where people had undertaken activities or taken baths these had not always been recorded in their daily notes. Where people had had baths this was not always being recorded.

Not all of the audits we saw at the previous inspection were used to improve the quality of the service. The manager told us "We are aware of the areas that still need looking at; there is a long way to go."

Improvements had been made to the cleanliness and infection control around the service. There were still areas around the service that required improvement including how people's laundry was cleaned.

We recommend that all areas of the service are maintained and cleaned to a suitable standard.

Staff had regular supervision and staff meetings and said that they felt supported.

We found during this inspection that sufficient improvements had been made to ensure that all recruitment checks were undertaken for staff. This gave assurances that only suitable staff were recruited.

In the event of an emergency such as a fire, each person had a personal evacuation plan and at each handover staff discussed these.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this report is 'Inadequate'. This means that it has been placed into 'Special measures by CQC. The purpose of special measures is to;

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement power in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such as there remains a rating of inadequate for any key questions overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the providers registration.

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.

Inadequate

There were not always enough qualified and skilled staff at the service to meet people's needs.

Staff did not always know about risks to people and how to manage them. People were not always receiving all of their medicines as prescribed.

Staff practices led to people being inappropriately restrained in their chairs.

The service was not always clean in all areas and there were not always adequate systems in place to help prevent the spread of infections.

Staff were recruited appropriately. Staff understood what abuse was and knew how to report abuse if required.

Is the service effective?
The service was not effective.

Inadequate

Staff did not have a good understanding of the Mental Capacity Act 2005 and people's capacity assessments were not always completed. Applications had not always been made to the local authority were people were being deprived of their liberty.

Staff had not all had up to date training to ensure that people's needs were being met.

People were not always supported to make choices about food. People were not always provided with enough to drink .

However people did say the food was good.

People had access to healthcare services to maintain good health.

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

Requires improvement

People were not always treated with kindness and compassion and their dignity was not always respected.

People were not able to express their opinions about the service and were not always involved in the decisions about their care.

Care was not always centred on people's individual needs.

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

People were not always supported to make decisions about their care and support.

There were not sufficient activities that suited everybody's individual needs.

People knew how to make a complaint and who to complain to.

Is the service well-led?

Inadequate 

The service was not well-led.

There were not always appropriate systems in place that monitored the safety and quality of the service.

People's views were not gained or used to improve the quality of the service.

People and staff thought the manager was supportive and they could go to them with any concerns. The culture of the service was supportive.

Birchlands

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Birchlands on 6 August 2015. This inspection was carried out to check that improvements made to meet the legal requirements planned by the provider after our 12 May 2015 inspection had been carried out. The team inspected the service against all of the five questions we ask about services: is the service safe, effective, caring, responsive to people's needs and is the service well-led.

The inspection was undertaken by three inspectors and one expert by experience. The expert by experience had experience of caring for or supporting people living with dementia and older people and has personal experience of using or caring for someone who uses this type of care service

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

During and after our inspection we spoke with the manager, the deputy manager, 14 people that used the service, seven relatives, 13 members of staff and two health care professionals. We looked at eight care plans, minutes of staff meetings, staff files and audits of the service. We observed some care being provided during the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were carrying out this inspection to follow up on concerns we had about the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 12 May 2015 the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection on the 12 May 2015 we found that there was a lack of robust practices that ensured that people received their medicines safely and staff were not following the correct procedures in relation to protecting people against the risk of infection.

We found during this inspection that there had been not been sufficient improvements to how medicines were administered. There was a risk that people may not have received the medicines as they were prescribed. One person was prescribed two types of topical cream (a medication which applied to the body to relieve itchiness or dry skin for example). The record stated that one had not been applied for eight days and the other had not been applied for 13 days as the cream had run out. This cream was supposed to be applied twice a day but the records indicated that it was only being applied once a day prior to the cream running out. Another person needed a cream applied three times a day. The records showed that this was only being applied once or twice a day.

The records relating to people's medicine were not always clear. Hand written medicine entries on people's medicine charts had not always been dated and signed or the amount of the new stock recorded.

As people were not always receiving their medicines and the recording of medicines was not always appropriate this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime medicines round. Staff explained to people what was happening and took their time with people. Staff waited for people to take their medicines before moving on to the next person.

We reviewed people's medicine charts and found no gaps or discrepancies. The medicine trolleys were stored securely within the service. We looked at the Medicines Administrations Records (MARs) charts for people and found that administered medicine had been signed for. All medicine was stored, administered and disposed of safely. Medicines management training was provided to the senior staff on duty.

People were not always protected from the use of inappropriate restraint. One person was sat at the dining room table and their chair was pushed in. The person repeatedly asked if they could be moved. They said "Can you please help me move this chair as I'm stuck." Although staff responded to them they made no attempt to allow the person to move. The person continued to ask to be moved for a period of thirty minutes. It was only after they asked a member of staff if they could be taken to the toilet that they were moved. Another person repeatedly asked a member of staff to remove their lap belt whilst they were sat at the dining room table. The person asked several times before the member of staff finally removed it.

People being restrained inappropriately is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On the 12 May 2015 inspection we found that staff were not ensuring that people were protected from possible risk of harm. Risk assessments were not up to date and incidents and accidents were not recorded in an appropriate way.

At this inspection we found that some but not all of these areas had been addressed. People were still at risk of harm. The manager told us initially that "Falls (to people) had reduced drastically due to more staff." However since the last inspection in May 2015 we found that falls had actually increased. The manager said that she realised that falls had increased and assumed this was because of one person who was falling constantly. However the records showed that it was more than one person who had fallen and the manager accepted that they had got this information wrong. One person was at risk of pressure sores, but steps had not been taken to reduce the risk of these developing whilst the person sat in their chair. As result this person had developed a pressure sore on their foot.

We looked at the risk assessments in people's care plans and found that these had not all been reviewed since the inspection in May 2015. Many had not been re-assessed since January 2015. In one person's care plan it stated on one risk assessment that the person was able to walk up and down the stairs (with support from staff) however we saw this person was no longer able to do this. The care plan

Is the service safe?

risk assessment had not been updated to reflect this. Another person was at risk of dehydration, there was no detailed information for staff around what they needed to do to ensure that this person was kept hydrated.

Staff did not always have knowledge of people's risks and we saw plans being put into action on the day of the inspection. One person had swollen legs. We were told by a health care professional that they would benefit from having their legs elevated but didn't think there were enough chairs in the lounge where the chair reclined. There was no information in the person's care plan around this and there was only one recliner chair that a family member had bought which was for another person. As steps were not taken to assess the risks to people and implement appropriate plans of action this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On the 12 May 2015 inspection we found that there were not enough staff deployed around the service to meet people's needs.

Some action had been taken to address the staffing levels but this was still not sufficient to meet the needs of people living at the service. There were not enough suitably skilled staff deployed around the service. When we arrived at the service we were told by the manager that staffing levels had increased and that there was one 'floating' member of care staff that would support all of the units. On each unit there was one permanent carer in the morning who was responsible for providing personal care to people, making breakfast, making people's beds and washing and drying up in the dining rooms. Each of the carers on the units were rushed and had no time to engage with people in a meaningful way.

The manager used a dependency tool to assess how many staff were needed on each unit. However it was clear from our observations that the levels of staff were not meeting the needs of people. We were told by the manager and staff that if they needed additional support then a 'floating' member of staff would be called upon to assist. This meant however that staff in seven different units relied upon the assistance of only one extra member of staff between all of them to assist them with care for people.

One health care professional told us "They (the service) lack people on the ground, the busiest time is in the morning." Staff told that there were not enough members of staff on the units in the morning. They said that there wasn't enough time to engage with people in the way that they wanted to. The manager said that "We need more staff; this is something we are looking at."

As there were not enough staff deployed around the service this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made to the cleanliness and infection control around the service. Since our last inspection on 12 May 2015 the provider has undertaken a 'deep clean' around the building. Additional infection control training had been provided to staff. However there were still areas around the service that required improvement. Large amounts of soiled and non-soiled laundry (some loose laundry) had not been kept separately from each other. The daily log for cleaning the tumble driers had not been completed since the 23 July 2015. We were told by the manager that the reason the laundry was piling up was because the member of staff that usually did the laundry was off sick. Another member of staff had not been allocated this job on the day. One bath on one of the units still had dirt and grime around the edges. We discussed this with the manager who said that this would be addressed straight away.

We recommend that the provider enures that all areas of the service are maintained and cleaned to a suitable standard.

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was a lack of robust recruitment processes before staff started work. Evidence of background checks had not been included in the staff files.

We found during this inspection that sufficient improvements had been made. A member of staff had been allocated the duty of ensuring that all of the recruitment files contained a check list of documents including records of staff full employment history, any cautions or convictions, two references and evidence of the person's identity. Volunteers that attended the service had also been asked to complete a criminal records check. This gave assurances that only suitable staff were recruited.

Inadequate

Is the service safe?

In the event of an emergency such as a fire, each person had a personal evacuation plan and at each handover staff discussed these. There were also action plans in relation to other emergencies affecting the service including equipment failure and fire safety.

Inadequate

Is the service effective?

Our findings

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the 12 May 2015 inspection we found that legal requirements were not being followed in relation to people's consent to care.

At the previous inspection in May 2015 staff did not have a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm. No additional training had been provided to staff to increase their knowledge since that inspection. We found that people were placed at tables with their chair pushed in to prevent them from standing up however staff did not appear to understanding why this could be restricting people of their liberty. One person had a lap belt on their wheelchair and asked a member of staff several times if this could be removed; it was finally removed once the person had been pushed up against the table.

At this inspection, there was no evidence that MCA assessments had taken place in relation to whether people were able to consent to decisions being made. No additional DoLs applications had been made to the local authority where these had been lacking on the previous inspection. One person's care plan had stated that they had been 'Restricted from leaving the building' however there was no evidence of any capacity assessments around this decision.

The lack of following legal requirements in relation consent to care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that since the inspection in May 2015 specific training had been provided to staff in relation to dementia and diabetes. Despite this we found that staff did not always provide effective care. One member of staff told us that they had only just started working on one of the units. They said that they had not had a handover with staff to get an understanding of people's needs. Another member of staff was not able to tell us anything specific around the needs of people with dementia. They told us that they had not been provided with training around this. Most of the people on the unit they were working on were living with dementia. We saw from training records that 11 out of 30 staff had not had updated training in safeguarding or manual handling training.

As there were not sufficient suitably qualified and skilled staff on duty to meet people's individual needs this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that before they started work they needed to complete the service's mandatory training including moving and handling and infection control. They also shadowed more experienced staff before they were allowed to provide care. One member of staff said "I had a good induction; I completed lots of training before I started."

On the whole there were positive comments from people about the quality of the food. One person said "It (the meal) was very nice." However people told us that they didn't always have access to drinks. One person told us that they had asked for a jug of water for their room at 08.45 but was not brought the water until 11.45.

There were varying experiences for people around meal times and whether they had access to sufficient drinks through the day.

We found people were not supported to eat and drink to maintain their health. On one unit people had been given drinks with their breakfast around 09.00. We saw that no drinks were left for them on the tables and were not offered another drink until 11.45 nearly three hours later. One member of staff said that there were not enough glasses for people from and they had to wait for the glasses to be cleaned in the dishwasher before they offered people drinks. We saw that in one person's care plan they were at risk of dehydration. This person was offered a drink with their breakfast between 08.30 and 09.00 and not offered another one until 11.45.

On one unit people were not offered a choice of what they wanted to eat. The two meals that were being provided did not reflect what was on the menu for that day. One relative asked a member of staff why their family member had not been provided with the meal they had chosen. The member of staff didn't know the reason why there were different meal options to what had been showing on the

Inadequate

Is the service effective?

menu. We asked the chef about this who said that there were not enough second options to go around and as they knew there were vegetarians on that unit they replaced the second option for the vegetarian option. They also told us that the fat fryer had been broken for around three weeks so had offered people mashed potatoes that day instead of sautéed potatoes. The information had not been shared with people living at the service.

One person had a pureed meal which had been separated into separate servings on the plate to improve the appearance. However when this was served to the person this was mixed up by a member of staff who then left the meal with the person to eat. Some people had little or no support to eat their meals despite their care plans clearly stating that they needed encouragement and support to eat. This person had lost weight however there was no information around how this had been addressed. One person waited over 30 minutes at the dining room table before they were served their food. Another person was not provided with a plate guard and struggled to eat their meal independently.

Peoples' nutritional and hydration needs were not always being met and this is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. People's weights were recorded.

There was not a safe or well-designed living space to provide the best care for people living with dementia. We saw that the environment of the service did not help people with dementia to be as independent as they could be. Although there was space for people to walk around independently inside the service (and we saw people doing this throughout the inspection) there were no clear signs to orientate people to the bathrooms, toilets or their bedrooms. There were no age appropriate points of interest for people to participate in.

People had access to a range of health care professionals, such as the community nursing team, and the GP. The GP visited once a week and people were referred when there were concerns with their health. One health care professional said that the care that staff provided to people was effective and that they had no concerns.

Requires improvement

Is the service caring?

Our findings

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of positive, respectful and dignified approach by staff towards people living at the service.

We found at this inspection that there was a mix of experiences for people dependant on what unit there were living on. People on the whole said that staff were caring. One person said "I like it here, the staff are very kind" and another said "They (staff) are very caring and very helpful." Relatives said that staff were caring. Comments included "They have many wonderfully kind staff here" and "I think the carers are absolutely fabulous, the care is great."

Other comments from people included "I feel that I am being a nuisance if I want anything" and "I don't feel wanted (here)." One health care professional told us that the television was not always showing age appropriate programmes and felt that no one was asked what they wanted to watch. We also found this during our inspection.

There were some interactions from staff that were not as caring and positive as they could be. One relative approached a member of staff about their family member's meal that wasn't correct. The member of staff did not address this or offer to call the kitchen for an alternative. Another lady was being brought back into the living room by a member of staff. The member of staff asked another staff member where they should this person should sit without asking the person where they would like to sit. Staff told us that there wasn't much of a chance to talk to people as much as they would like in the mornings as it was too busy.

People were left on their own for long periods of time without any interactions with staff. Staff were focused on completing tasks and did not always have time for people.

On one unit we saw one person sat on their own on the sofa. They were not spoken to for over an hour until the lunch time meal was served. During this time the person kept drifting off to sleep. One person had a child's puzzle placed in front of them on the table but there was no attempt by staff to interact with the person or to do the puzzle.

There was at times a lack of respect for people and staff did not always consider how their actions could impact on people. The glasses that people were being offered a drink in were hot as they had just come out of the dishwasher. The member of staff remarked that they would have preferred to give people the cold drinks in cool glasses but they said there were not enough glasses around. The manager told us that there were spare glasses in all of the other units and kitchen and the member of staff could have used them. We overheard one member of staff become very agitated at another member of staff in front of people as they were unsure about who wanted what meals.

People were not always treated with dignity and respect which is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some caring and kind interactions with staff and people during our visit. One person did become distressed and agitated, staff responded to this in a calming and reassuring way which settled the person. We saw several examples of laughter and chatting between staff and people and we saw that people enjoyed that. One member of staff came on duty after lunch and greeted people warmly and with affection which people responded positively to.

People's family and friends were able to visit at any time and we saw this happening throughout the visit.

People were able make decisions, have their privacy and independence and this was respected by staff. We saw people choose to sit in their rooms if they wished and heard staff knock on their doors before they entered.

Inadequate

Is the service responsive?

Our findings

At our previous inspection on the 12 May 2015 the service was in breach of Regulations 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On the 12 May 2015 inspection we found that there was a lack support for people to encourage independence. People were not experiencing meaningful activities to suit their needs.

During this inspection we found there were some improvements to the activities available to people as additional activities coordinators had been recruited. However we found that on each unit there were not enough meaningful or individualised things for people to do. We saw on one unit that there was a small sideboard with a small amount of games, some of which were not age appropriate, for people to play with. We saw two people playing dominoes independently however there was nothing else for other people to do. We asked staff on this unit what the activity of the day was and they said they did not know. They said people would have been asked that morning if they wanted to join the activity downstairs. They told us that people on that unit did have short term memory loss so may not remember being offered. Another member of staff said that it was difficult to encourage people to leave the units for activities.

We did not always see staff encourage people to access any activities on the unit other than the radio being played or the television being on. No one was watching the television on one of the units and staff didn't take the time to ask people what they wanted to watch.

There were some activities taking place in one of the large lounges on the ground floor which around four people participated in. We saw people enjoyed these and were happy to take part. We saw that these had been offered to all of the people on all of the floors first thing in the morning.

Care was not provided in response to people's needs. On 3 August 2015 it had been recorded in one person's care plan that they needed to be on a food and fluid chart to monitor that they had enough to eat and drink . This chart had not been started and the staff on duty did not know anything about this. People who were living with dementia did not always have a plan of care around how to meet s their individual needs.

Information was not always shared or communicated well between staff around people's care. On one unit one person had been unwell in the morning and had been seen by the visiting health care professional. A note of this was not made on the person's daily notes and the information was not shared with the member of staff coming on duty. We saw that on another unit at 16.55 seven care plans had not had care notes written in them since the previous day. For example one person had developed a rash on their arm in the morning; this had not been documented in the care plan. We did note however that this person had visited the GP about this.

Staff did not always have information about people's backgrounds. There was not always information in care plans around people's life histories and their preferences. There was a section on people's 'Life stories' that had not always been completed.

People were not receiving care and treatment that was specific to their needs or wants. This is a breach of regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see that some people's care plans had been reviewed since the last inspection and that these reflected the person's up to date needs. This included information around people's mobility, medication, communication plan, and nutrition and skin integrity.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on the 12 May 2015 the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the 12 May 2015 inspection we found that there was a lack of accurate records held in the service and improvements had not been made in relation to the quality of the service.

We saw that some improvements had been made but there were still gaps in the records around the care that had been provided. Where people had undertaken activities these had not been recorded in their daily notes. Where people had had baths this was not always being recorded. One member of staff said that staff kept forgetting to sign to say when people had had baths even though they had been reminded to do so. One person had been prescribed a cream for their legs for a six week period but this had not been dated so it was unclear when the medicine started and when it needed to cease. The manager told us that they were still working on the gaps in people's care plans. As there was a lack of accurate records held in the service for people this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all of the audits we saw at the previous inspection had been used to improve the quality of the service. On this inspection we found that audits of care plans had been undertaken. We found that these had not always been dated. Where concerns had been identified improvements had not always been made. In two care plans the audit stated that the person's file did not contain the person's 'life story.' We found that this was still the case on the day of the inspection.

We found that there was a lack of consistency in how the service was operated and managed. People's healthcare needs were not always being managed effectively and risks were not appropriately identified or managed. This resulted in people not receiving good care. Although there were some systems in place to quality assure the processes none of these were identifying and addressing the inconsistency of care around the units. There was a lack of direction and leadership on some of the units which impacted on the level of care people received.

Although the provider sent us a plan to tell us that they had addressed the shortfalls of the May 2015 inspection we found that this was not always the case.

The lack of assessment and monitoring of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that they were tracking were ensure that all of the areas of concern we identified before were being addressed. These were on display in the manager's office. This helped to ensure that areas for improvement were constantly being reviewed. Where staff required performance management this was being addressed. The manager told us "We are aware of the areas that still need looking at; there is a long way to go."

Staff said that they had regular supervision and staff meetings and that they felt supported. One relative told us that they thought that the service was well- led as problems had been sorted out immediately for their family member.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured people were treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had not ensured that care and treatment was provided to ensure people's needs were met.**

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 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered provider had not ensured that people received appropriate hydration and nutrition.

The enforcement action we took:
As this is a breach we issued a warning notice to the registered provider on the 9 September 2015 in relation to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We have set a timescale of 28 September 20115 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

The enforcement action we took:
As this is a breach we issued a warning notice to the registered provider on the 9 September 2015 in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We have set a timescale of 28 September 2015 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of inappropriate or unsafe care or treatment because effective systems were not in place to assess the quality of the care.

The enforcement action we took:
As this is a breach we issued a warning notice to the registered provider on the 9 September 2015 in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

We have set a timescale of 28 September 2015 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not ensured that people who use services were cared for by sufficient numbers of qualified, competent and experienced staff.

The enforcement action we took:
As this is a breach we issued a warning notice to the registered provider on the 9 September 2015 in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We have set a timescale of 28 September 2015 by which the registered provider must address this breach.