Woodhouse Care Homes Limited

Pranam Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 November 2016 and was unannounced.

The last inspection took place on 22 March 2016 when we found five breaches of Regulation relating to safe care and treatment, the environment, person centred care, display of Care Quality Commission rating and lack of a registered manager. At this inspection we found that improvements had been made in some areas but further improvements were needed.

Pranam Care Centre is a care home which provides accommodation and personal care for up to 50 older people. Some people were living with dementia. At the time of our inspection 33 people were living at the home. The service was registered with the Care Quality Commission in June 2015. The service was managed by Woodhouse Care Homes Limited, a private organisation. Although Pranam Care Centre was the only service operated by the provider, the company directors also managed other organisations providing residential and domiciliary care services in England.

There was a registered manager in post. 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.

People were not always safe because some of the practices at the service put them at risk. The environment was not always safe or clean. Procedures for managing medicines were not always followed safely. Risk assessments did not always identify how staff should manage the risk and keep people safe.

People's leisure and social needs were not always met in a way which reflected their preferences.

The provider did not always have all the required documentation in place for the staff employed at the service.

The provider had not always acted in accordance with the Mental Capacity Act 2005 because information about people's capacity and their consent to care was not always clearly recorded. In addition the staff did not understand the principles of the Mental Capacity Act 2005 or their responsibilities under this.

Not all staff treated people with dignity and respect.

Records were not always well organised or clear.

The provider had made improvements in some areas but these were not enough and people were still placed at risk because the service was not always well-led.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The environment was not designed in a way to support people who had dementia and help them to orientate themselves. We have made a recommendation in respect of this.

Not all staff had good English language skills and this meant there was a risk they would not understand or meet the needs of people who lived at the service. We have made a recommendation in respect of this.

People's personal care, health and nutritional needs were being met.

Some of the staff were kind, caring and treated people with compassion.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some staff practices put people at risk.

Risk assessments did not include information about how to minimise risk of harm or injury.

Parts of the environment were unsafe or not clean and hygienic.

The procedures for the safe management of medicines were not always followed.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not always act within the principles of the Mental Capacity Act 2005 because people had not always been asked to consent to their care, the staff did not have a good understanding of the principles of the Act and information about people's capacity was not always clear.

The environment was not always suitable for people who lived at the service.

The English language skills of some staff were not sufficient to ensure people's needs were met.

The staff worked with healthcare professionals to make sure people's health needs were assessed, monitored and met.

The staff had the training and support they needed to care for people.

People's nutritional needs were being met.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some staff interactions were task based and did not show people respect.

There were also some positive, kind and caring interactions.

People felt the staff were kind and caring.

People's privacy was respected.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's social and leisure needs were not always met and did not reflect their preferences.

There were plans for meeting people's care needs, although these were not always clearly recorded.

Most people felt their care needs were being met.

Complaints were investigated and acted upon and the provider asked people using the service and their relatives for their feedback.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had made improvements in some aspects of the service but people were at risk because staff practices were not always safe. In addition, people did not always receive person centred care which reflected their needs and preferences.

The provider's audits were not up to date.

Records were not always accurately maintained.

Most people liked living and working in the service and felt supported by the registered manager.

Pranam Care Centre

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 22 November 2016 and was unannounced.

The inspection visit was carried out by two inspectors and an expert-by-experience.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and the last inspection report. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience supporting this inspection had personal experience of caring for someone who used registered services.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and the last inspection report.

During the visit we spoke with ten people who lived at the service and four visiting relatives. We spoke with one visiting professional advocate. We also spoke with staff on duty who included the registered manager, senior care workers, care workers and the chef. At the end of the inspection we gave feedback to one of the provider's directors and the registered manager.

We observed how people were being cared for. Our observations included a Short Observational Framework Inspection (SOFI) during the morning. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care records for six people, including care plans, risk assessments and records of care provided. We looked at the staff recruitment records for four members of staff. We also looked at other records the provider used for managing the service, such as records of complaints, staff training,

safeguarding alerts and audits. We saw how medicines were stored, administered and recorded. We looked at the environment.

Inadequate

Is the service safe?

Our findings

At our inspection of 22 March 2016 we found that people were sometimes placed at risk because of poor practices at the service.

We witnessed two incidents during 22 November 2016 where a person using the service was placed at risk because of the way in which they were being supported. The person was seated in a wheelchair for the duration of our visit. On one occasion a member of staff was seen pushing the wheelchair along without noticing that the person's foot was caught between the floor and the wheelchair foot plates. Another member of staff shouted what was happening and approached the person to help ensure their foot was placed safely on the foot plate before they continued to move.

In another incident the same member of staff pulled the person a short distance by holding the top of their shoes and pulling them along.

These incidents were reported to the registered manager during the inspection visit who agreed to speak with the staff member involved. However these practices were not safe or approved ways to support people to move and placed this person at risk.

Throughout the building we found rooms were not always equipped with call bells and some of the cords attached to the bells had been looped or tied up in a way which prevented them from being reached in the event of someone falling to the floor.

Four fire extinguishers on the first floor had been removed from their normal positions and were situated together by a door to the first floor lounge. There were sections of the corridor through coded doors where there were no extinguishers. The staff told us that this was because two people who lived at the home had taken these and thrown them presenting a risk. One staff member said, ''[Person] takes the extinguishers off the wall and also [another person] gets angry and throws the extinguishers.'' We found records of one incident where this had happened. The fire risk assessment had been updated to record that the fire extinguishers had been relocated. The provider told us that all staff were aware of this procedure. We saw that this had also been recorded on the risk assessment for one of the people involved. However, there was no record of this on the risk assessment for the other person. The risk assessments indicated how the risk of further incidents with the extinguishers should be managed, but did not record any changes in the fire fighting procedure, due to the relocation of extinguishers, which the staff needed to be aware of. The record of the incident where one person had thrown a fire extinguisher did not include evidence that alternative ways of supporting this person to prevent reoccurrence of the incident had been considered. However the risk assessment for the other person did include this information.

In the first floor shower room we found a used disposable razor, two bottles of shampoo and two bottles of shower gel which had not been securely stored. The registered manager removed these. There were also hot water pipes in this room which had not been lagged and were hot to touch. The fixtures to secure the pipes to the wall had come loose and there were exposed nails. People living at the home experienced dementia

and could be placed at risk from these potential hazards. However, the provider reported that all people using the room were supervised apart from one person who had capacity to judge risks. The provider thought that the risk to people was minimal and took action to address the areas of concern following the inspection visit.

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

At our inspection of 22 March 2016 we found the environment was generally well maintained but had not always been cleaned.

During our visit of 22 November 2016 we found a malodour in the main lounge on the ground floor throughout the day. There was also an unpleasant smell, which the registered manager thought might be a problem with the drains, around the sensory room and small lounge. Shower rooms on both the ground and first floor smelt of damp and the extractor fans in these rooms were dusty. The shower hose and head in the ground floor shower room were resting in a bucket of dirty water. The shower hose in the first floor shower room was marked with limescale.

This was a repeated breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Following the inspection visit the provider reported that extractor fans were fully functioning and there were no longer any malodours in the shower rooms.

Medicine procedures were not always followed and there was a risk of people not receiving their medicines as prescribed.

One person who lived at the service told us that they did not always receive their medicines as prescribed. They said, ''I should have my medication three times a day but on two days since I have arrived it has only been twice a day. On another occasion they gave me two [of a specific medicine] in the morning instead of one in the morning and one in the afternoon.'' One visiting relative told us that there was an incident in August 2016 when their relative did not receive their medicine as prescribed.

Some medicines were not stored securely. A tube of antibiotic medicated cream had been left on the desk in the office. There was also an unlocked plastic storage box containing a variety of medicines. The senior member of staff told us that this was medicines which had been received from the pharmacy at the weekend but they had not had an opportunity to sign these in or store them in the trolleys. The provider did not have a record of these medicines apart from the administration charts which had been delivered with the medicines. However, these had not been checked for any discrepancies. We also found medicine supplies for a person who had left the service left on top of the box. There was no record of this medicine. The refrigerator used for storing some medicines was not locked. The registered manager told us that the door to the office was locked when the staff were not present. However, this was not the case on the day of the inspection. In addition, we saw that people who lived at the service, visitors and staff who had not been trained in medicines procedures walked into the room at various times during the day. This included times when the senior member of staff was busy attending to a task or not in the room. Therefore there was a risk that people could access these medicines and because there was not a clear record of all of the medicines there was a risk it would go unnoticed if medicines were removed.

Senior staff were responsible for administering medicines.. On the day of our inspection the morning medicine round took the member of staff three and a half hours to complete because they were unfamiliar

with the people who lived there and the service. Medicines trolleys were stored on the ground floor and the member of staff took medicines individually to each person on all floors. Because the medicines round took so long some people were not receiving their 8am medicines until 11.30am. The member of staff told us they felt the service needed two staff responsible for administering medicines. They said that the registered manager sometimes helped with this. We discussed this with the provider and registered manager who agreed that they would review the medicines administration procedure. They showed us an action plan which included increasing the number of senior staff on duty each morning with both having responsibilities to administer medicines.

For people who had PRN (as required) medicines there was a protocol in place to state when they should be administered this medicine. However, one of these protocols had been due for review in June 2016 and there was no evidence this had happened.

The medicine records for two people who had recently moved to the home did not include a record of the amount of each type of medicine they had brought with them. In addition one person had a number of vitamins and homely remedies which had not been prescribed. There was no evidence that the provider had discussed the use of these with the GP to ensure that they were safe and suitable for the staff to administer to the person.

There was a record of sample signatures of staff who were responsible for administering medicines. However we noted the member of staff who administered medicines on the day of the inspection had not provided a sample signature.

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

We carried out an audit of the medicines for five people using the service. Their current medicines were stored appropriately in locked trolleys. The staff recorded the temperature of the medicine trolleys and refrigerator each day. Medicine administration charts had been signed to denote administration or if medicines had not been administered and the reasons for this.

Care records included information to show that the risks to people had been assessed. For example, we saw risk assessments relating to skin integrity, risk of falling and nutritional risk. But the assessments did not include plans to tell the staff how they would manage the risk and support the person. For example, on person had been assessed as at ''medium risk'' of falls. The risk assessment did not include any information about the support the person should be given to prevent them from falling. Some of the information within risk assessments was generic and did not reflect individual need. For example one risk assessment stated, ''monitor the service user's whereabouts.'' Another risk assessment stated the person's ''behaviour is very aggressive.'' But there was no description of the challenges the person may present or the support they needed to keep them and others safe.

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

The provider had procedures for safeguarding vulnerable adults and whistle blowing. The majority of staff had received training in these. The provider's training records indicated that ten members of staff were in the process of completing on line training about safeguarding adults but had not completed this, although some of these staff told us they had completed the training with previous employers. Most of the staff who we spoke with had an understanding of different types of abuse and knew that they should report these to

the registered manager or local authority. The staff also had an awareness of people's vulnerability because of their dementia. Some staff did not know about the local safeguarding authority and their role. We discussed this with the registered manager who agreed to address this in a team meeting and learning session where the procedures for responding to and reporting abuse would be discussed.

Where there had been allegations of abuse at the service the provider had responded appropriately. They had worked with the local safeguarding authority to investigate concerns and to protect people using the service. They had also notified the Care Quality Commission about the alerts and subsequent action and outcome of the investigations.

Some of the visitors we spoke with told us they did not think there was enough staff, however people felt that their needs were being met and they did not have to wait for care.

At the time of the inspection there was no deputy manager at the service. The registered manager told us they were observing specific staff with the view to appointing them in the role of deputy manager. The provider had recruited an activity coordinator in August 2016 who worked at the weekends and one of the care workers had specifically assigned hours to provide activities during the week days. The registered manager was reviewing the need for more senior staff to be employed each morning to assist with medicine administration and supporting the other staff.

There was one chef employed at the service. They told us they did not have any kitchen assistants.

The provider had appropriate procedures for the recruitment of new staff. These included a formal interview with the registered manager. We looked at the recruitment files for four members of staff. These contained an application form, references, evidence of identification and proof of eligibility to work in the United Kingdom as well as evidence of checks on their criminal record. However, one member of staff had not explained gaps in their employment history in their application form and these had not been discussed at interview. We discussed this with the registered manager who agreed to discuss and record the reasons for any gaps in staff member's employment history. In addition two members of staff had recorded they had worked in health and social care settings in their recent employment history. But the referees they had given were not managers or employers from these care homes or agencies and were from past unrelated employment or personal references. We discussed this with the registered manager because providers are required to obtain satisfactory verification of their previous work with children or vulnerable adults where reasonably practicable. The registered manager agreed to look at the information provided by these members of staff and request references from related previous employers.

This is a breach of Regulation 19, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 22 March 2016 we found people's healthcare needs were not always being met because the staff had made decisions about their health which were not based on best practice and without the consultation of relevant healthcare professionals.

At the inspection of 22 November 2016 we found improvements had been made. People's health needs were recorded in their care plans and there was evidence the staff consulted with relevant healthcare professionals. A local GP visited the service each week and met with people as required. There were records of healthcare consultations.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA and made DoLS applications appropriately.

Information about people's capacity to consent varied in quality and accuracy. In one person's care records there was evidence of a DoLS authorisation and discussion with the person's family about their best interests but the assessment of their capacity had not been completed and it was not clear which decisions, if any, the person had capacity to make. In another person's care records there was no evidence of a DoLS authorisation, however we were made aware of this and shown a copy by a visiting professional. The way in which information about capacity and consent had been recorded was not always clear or appropriate. For example, one care plan stated, " I do not need DoLS, I do not have mental problems."

We looked at the care records for two people who the registered manager had told us had capacity to make decisions and consent to their care. Neither person had been asked to sign agreement to their care plan and there was no evidence to indicate these had been discussed and agreed with them.

We spoke with the staff about the MCA and their roles and responsibilities in relation to this. The staff did not have a good understanding of the principles of the Act or how this affected the way in which they supported people. For example one member of staff said, ''We need to see if people can or cannot do things. We know it as they know the way they behave and they have care plans.'' Another member of staff told us, ''I have had the training, some people are always screaming, some very quiet, some too much speaking, we have to talk to them.'' A third member of staff told us they thought that MCA and DoLS were the same thing and could not describe what was meant by either of these terms. One member of staff told us they knew that some

people living at the home had capacity to leave the building if they wished. However, they went on to say that if people left the staff should follow them.

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

Some of the staff had a clearer understanding of the MCA. One member of staff told us, ''Whatever we do, we do it in their [people's] best interest, if they are not able to understand we do it for them.''

Two care records we looked at contained appropriate and clear information about people's capacity to consent and DoLS applications. In both cases a named representative had been involved in making decisions about their care in the person's best interest and had signed their agreement with care plans.

Accommodation was provided on three floors. There were lounges on each floor, but the majority of people spent time in the lounge or foyer area on the ground floor. People told us they enjoyed spending time sitting in the main foyer which was light and airy. There were two dining rooms on the ground floor.

However, the environment was not always suitable or appropriately maintained to meet people's needs. A toilet seat in the shower room on the first floor was broken and had become detached from the toilet. Hoists were placed in front of the door to the garden making access to this area difficult. Visitors reported this was always the case and that the door had a raised frame which they considered a trip hazard. The registered manager told us, ''We only use the garden in the summer, sometimes the residents go for a walk around the carpark.'' The provider told us that access to the garden was supervised and the hoists were only stored in front of the door when the garden was not in use. The television in one communal room had been removed because it had been broken. One person who lived at the home told us that the other communal television did not work because of a problem with the signal. Following the inspection visit the provider told us, ''Where the toilet seat was broken -was something that happened recently at the time, maintenance is ongoing on daily basis Engineers had been called in to repair the TV and the satellite signal. It is pretty normal to have ongoing maintenance issues.''

The sensory/activity room was used to store paperwork and files. The door handle to the room was damaged. There were no clocks in the main dining room or lounge, meaning that people could not easily see the time. There was a photographic menu board and photographs of staff on display but other information on display was not always clear, accessible, in date or easy to read.

Bedrooms were labelled with people's names and some had a photograph of the person. However, these photographs were not always appropriate. For example, some of them had been printed in a way that the person's face was squashed or elongated. In one photograph the person appeared to be asleep. In addition, people had not been consulted about whether they wished to have a photograph of themselves on the bedroom door. Some people may prefer other visual clues to help identify their room. One of the names on a bedroom door had been crossed out and changed, making the name unclear.

There were limited other distinguishing features to help people orientate themselves. The walls were painted a similar cream colour throughout. The lighting, colour schemes and textures of the environment did not reflect good practice guidance for environments for older people and those who were living with dementia.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes

incorporating features that support spatial orientation and minimise confusion, frustration and anxiety.'' The guidance also refers to the use of ''tactile way finding cues.'' The government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.'' These guidelines are also relevant for other older people who would benefit from these environments.

We recommend that the provider considers how they can implement good practice guidance to enhance the environment.

Following the inspection visit, the provider told us, ''We have always had an inventory list for activity tools for dementia bought from dementia website set up in 2015 when home opened and is not completely exhaustive. It has all the touch, smell, hear, feel, lamps, old photographs etc. in the room. The sensory room is not used for storing books etc. but these items are used when the residents use the sensory room for sessions.'' They also said, ''We have come a long way in improving our dementia friendly atmosphere. We have created one of our lounges by putting in arm chairs that look like those from old days, stools, ceramic designed plates with photos from 1950s, furniture that looks like the old days, book shelves with books, creating surroundings that make residents feel like they are in their own home. We actually get complimented by families and residents about how happy they feel in the home that looks like their home. There are a lot of individual items of furniture scattered around the home that would remind residents of the furniture and items they used to use once upon a time. It is a big home and we are progressing all the time to make it more dementia friendly.''

People living at the service and their visitors told us that the staff had the skills they needed to care for them. However, we noted that one member of staff working on the day of our visit had very limited English language skills. They were unable to answer questions from the inspection team and we witnessed them misunderstanding things that both people living at the service and other staff said to them. We spoke with the registered manager about this and they said that although some of the staff did not have good English skills they were ''caring'' and ''had the right attitude.'' However, there is a risk that staff who cannot understand English may not be able to meet the needs of people and could put them in a situation which is unsafe.

We recommend the provider ensures that all staff have the skills and ability to understand and communicate in English.

The staff told us that they had received a range of training to help them in their roles. This included an induction which covered first aid, health and safety, safeguarding adults, food hygiene and infection control. The staff also undertook a number of different on line training courses. The registered manager was able to check each member of staff's progress and completion of these courses. Some staff told us they had received training from previous employers and had been asked to show the registered manager evidence of this.

The registered manager had an overview of staff training, including when updates were due. We saw that some staff still needed to complete some of the on line training courses. The registered manager told us that they had discussed this with the individual staff.

The staff told us they felt supported by the registered manager. They said there was good communication between the staff, including plans for each shift and communication with other departments, such as the

maintenance department when repairs were needed.

We saw evidence of team meetings, individual and group supervisions. At these meetings the registered manager and staff discussed their roles and responsibilities, praised good practice and set actions where improvements were needed. Some of the meetings included themed learning sessions, for example about nutrition, falls and dementia. The registered manager told us they would be conducting more of these in the future.

People's views on the food at the service varied. One person said about the food, ''Well it's something to eat.'' Another person told us, ''It can be a bit greasy, but I complained and it got better.'' However, other people spoke positively about the food. One person said, ''There is always a choice and the menus are good, I like the food.'' Another person said, ''The food is great.''

There were two main menus each day, an Asian menu and a traditional English menu. People could make choices about what they ate. Alternatives such as jacket potato, omelettes, salads and sandwiches were also available.

People's nutritional needs were recorded and they were regularly weighed. There was evidence that the staff had referred people to appropriate professionals when they had concerns about someone's weight, diet or swallowing difficulties. However, one visitor told us care plans were not always followed as they had recorded specific food their relative did not like, which they saw them being given. They commented that this was a day when a different chef had been on duty and normally the regular chef knew the person's likes and dislikes. The chef had information about each person's diet, likes, allergies, dislikes and preferences and demonstrated a good knowledge to us, including where people had health related dietary needs.

Requires Improvement

Is the service caring?

Our findings

The majority of people who we spoke with told us the staff were kind and caring. One person told us, ''It's a good home, because they're nice people.'' Another person said, ''They do some good work here because people find it hard in the world. They do a lot of healing work." Another person commented, ''I am fine, the staff are good, everything is fine.'' One visitor told us that their relative's keyworker was very good, but that other staff were not as kind.

We witnessed one interaction during the morning in the main lounge where a member of staff gave a person a drink. They placed a plastic apron on the person and tucked green paper towels into the top of their clothing. They then stood over the person whilst they were drinking and did not leave them until the person had finished their drink, at which point the person took the apron, towels and cup away without speaking to the person. We later saw the same person having another drink. The person was independent in doing this and did not require any assistance from the staff or any protective clothing.

Some people did not have a positive mealtime experience at lunch time. In the small dining room, the staff bought people trays of ready plated up meals and did not offer people a choice at the point of service. The staff did not tell people what the food was and only spoke at all to a small number of people offering them a drink. The staff handed people cutlery after they had given them their food and in some cases offered the cutlery with the handle facing away from the person. The staff did not ask about people's enjoyment of the meal or offer condiments or second helpings.

A small number of staff in the main dining room appeared focussed on the task they were performing rather than the person they were caring for. We heard one person asking a member of staff for something. The member of staff responded by saying, ''Sit down, when I have finished her [pointing to another person] I will come to you.'' In another interaction we heard a member of staff asking another, ''Who is for feeding?'' When supporting one person who had a pureed meal, a staff member mashed the food together with a fork, mixing up the different elements on the plate. These interactions and incidents indicated that the staff were not considering the perspective of the person they were supporting and how they might feel.

There were two occasions where we heard a person telling the staff a joke and one occasion where the person told the staff member a story about their past. In all three cases the staff member gave no acknowledgement of the conversation, twice not saying anything and the third time saying, ''Do you want a drink?''

One member of staff (who had worked at the service for more than six months) told us about a person and a recent incident involving them. We asked for the person's name. At first the staff member could not recall their name. They then told us, ''We all call them [the person's surname], that is what [they] like to be called.'' Following this we looked at the person's care plan. The plan and all documents within this stated that the person's preferred name was a different name. None of the documents indicated the person wished to be called by just their surname.

One person was seated in a wheelchair which was labelled with another person's name.

We saw a number of incidents were the staff escorted someone into a room or pushed their wheelchair into the room and then left without any communication with the person. We also saw the staff ignoring people who asked for drinks.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also saw some kind and positive interactions between the staff and the people who they were caring for. In the main dining room at lunch time some staff were very caring and considerate. They offered people choices, explaining what their meal was and, in one case, explaining the arrangement of food on the plate of a person who had limited sight. People were offered condiments and second helpings. We also saw the staff asking people if they wanted to wear protective aprons and respecting their choice when they said they did not want to.

In addition we heard staff speaking with people in people's first language and using terms and language seen as respectful in the person's culture. Some staff spent time gently touching people's hands and approaching them in a kind and supportive way.

The staff respected people's privacy, offering care behind closed doors and talking sensitively and quietly about people's needs. We saw examples where they helped people to adjust their clothes when they were seated to maintain their dignity.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 22 March 2016 we found that people's individual social and leisure needs were not always met and did not reflect their preferences because there was limited organisation and support with social activities.

At the inspection of 22 November 2016 we found that improvements were minimal and people's individual social and leisure needs were not being met.

People living at the service and their visitors told us they did not feel there were enough activities. Some of their comments included, ''I stay in my room most of the time, I like to watch TV but it has not worked for two weeks'', "[They don't have] enough space for everybody to do things. There are no activities anywhere. There's nowhere to go. The TV comes and goes – there's no signal… I am very aware there are people who would rather be doing something other than sitting there'', "There is nothing much to do. We just hang around", "There are no activities. [Our relative] says she is bored", ''They should involve [my relative] more with simple things to do like folding paper or colouring, but they do not'', ''They do not make use of the garden even in the summer'', ''People like sitting in the foyer but [the staff] try to stop people sitting there'', "It's not quality, for me it is not good here" ''There are no activities and I keep myself occupied, walking in the grounds, reading and watching TV.''

During the morning of our inspection the majority of people did not engage in any social or leisure activity except with visitors. An exercise session lasting ten minutes took place in one lounge midmorning followed by five minutes of throwing a large balloon between people. Only three people enthusiastically joined in the exercise activity. People had not warning that the activity was planned and no alternative was offered.

Following these activities a member of staff gave a person a board game to play. However, they did not interact with the person and took the game away after less than four minutes. The game was incomplete and pieces were missing.

There were no other activities offered to groups or individuals for the rest of the morning. In the afternoon the staff turned modern music on in the lounge. We asked if this was the choice of people living at the home. The staff member then turned the music off and stated, ''They usually listen to classical music.'''

We looked at the activity records for eight people over a two week period preceding the inspection. Records stated that five of the people had refused any activity for the majority of days. Other records had little variation with exercise most days, two records showing ''skittles'', two recorded ''walks'', one recorded, ''chat'' and two recorded, ''balloons.'' Two people had an entry stating, '''because of a very busy day unable to do a social activity'' on one particular day. Two people also had record stating, ''[Another person]'s birthday'' on one day. There was no indication about how the person the record was about had been involved in celebrating the person's birthday. There was no indication to show how long any of these events lasted. From the observations on the day of the inspection the organised activities were short, were not meaningful for most people and did not reflect their needs, preferences or interests.

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

Since the last inspection the provider had employed an activities coordinator who worked during the weekends and had assigned specific hours for one of the care workers to provide activities during the week days.

The provider showed us the weekly planner of activities for the week of the inspection. This showed that on the morning of the inspection the planned activities were, ''Gentle exercises and jigsaw puzzles'' and the planned activity for the afternoon was ''Exercises with [named coordinator].'' The provider told us that this meant people living at the home ''Knew what activities were going to take place.'' The activity planner recorded that the activities for the rest of the week were, ''Gentle exercise and birthday celebrations'' on Monday, ''Gentle exercises, playing ball and one to one chat'' on Wednesday, ''Gentle exercise, art and craft and group worship'' on Thursday, ''Gentle exercise, skittles and playing cards'' on Friday, ''Family time, floor basketball and birthday celebrations'' on Saturday and Sunday.

The majority of people living at the service and their visitors who we spoke with told us they felt care needs were met at the service. However one visitor told us they were concerned that their relative did not had regular showers. They also reported they found their relative wearing someone else's glasses and their relative's glasses had been misplaced at the service.

One person told us they were happy with the care they received they said, ''I have participated in writing my care plan.'' One relative told us, "I have no complaints as far as [my relative's] care goes; [they are] always clean, always changed."

We saw that people appeared clean and dressed in their own clothes, which were suitable for the weather and how they were spending their day. Records of care provided indicated that people had regular showers or baths and were supported with their personal care.

People's care needs were recorded in care plans, which varied in amount of detail and clarity. Some of these did not have consistent information and needs had not been recorded. For example one person was at risk due to their mental health condition. However, this was not clearly recorded throughout the care plan. In another example, a person had been referred to a healthcare professional for support with one aspect of their care. There was evidence there had been a consultation with this professional but the guidance had not been incorporated into the care plan.
In addition care plan reviews did not always clearly record the changes in people's needs which were recorded elsewhere in the records. Therefore it was difficult to determine what the current plan of care for some people was and whether their needs had changed.

The staff told us they did not always have time to read the care records, in particular additional information which did not form part of the main care plan. In most cases the initial assessment of need made before the person moved to the service was the first part of the care record in the files. Updates and changes to care were filed in different places and not always easily accessible. Therefore changes to the person's health or care needs could not easily be identified except by detailed examination of each part of the record.

There was a procedure for complaints and this was displayed. One visitor told us they did not think complaints were responded to appropriately. However, most people told us they knew how to complain and felt their concerns would be listened to.

We saw a record of formal complaints. This included information about the investigation into the complaint and action taken.

The provider had asked people who used the service and their representatives to complete surveys about their experiences. Relatives had completed their surveys in June 2016 and 13 of them had responded. People living at the service had completed surveys in October 2016 and 14 people had responded. Feedback was generally positive. However, a staff member had assisted people using the service to complete surveys. We discussed this with the registered manager who agreed that an independent advocate, volunteer or family member would support people in the future so that the results of the survey could not be influenced by staff working at the service.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 22 March 2016 we found that there had been no registered manager in post since August 2015 and no application to register a new manager with the Care Quality Commission had been received.

The provider had recruited a manager who started work in August 2016. They were registered with the Care Quality Commission in November 2016. The registered manager had experience of working and managing care homes and nursing homes.

At the inspection of 22 March 2016 we found the provider had not displayed their most recent Care Quality Commission performance rating on their website. The provider told us they had not been aware of this requirement and agreed to take action to ensure the rating was displayed.

At the inspection of 22 November 2016 we found that the provider's website included a link to the Care Quality Commission (CQC) website where the most recent inspection report and rating could be viewed. Although the rating was not displayed on the provider's own website, nor was any reference to the report or the role of CQC. We could not find the rating displayed at the service. The registered manager showed us that the most recent inspection report and rating were attached to a notice board in the main foyer, but this had been covered up with other documents so it could not be seen. The registered manager agreed to rectify this straight away to ensure the rating was displayed at the service and we noted that it was visible by the time we left the service.

At the inspection of 22 November 2016 we found improvements had been made in some areas. However, people were still being placed at risk from unsafe practices and an unsafe environment and people's social and leisure needs were not always being met.

Records at the service were not always clearly maintained. For example, some of the care plans did not indicate when people's needs had changed or how the supported they needed had changed. The report of an incident in one person's file had writing all over the paper making it difficult to read and determine what had happened. In addition some records were poorly organised. There were a variety of records stored on the office desk which had not been appropriately filed or stored. These included parts of some care records, staff communication books and memos, one person's freedom pass, a driving licence, shop loyalty cards and a bingo card. During the inspection the registered manager told us that another person's freedom pass had been misplaced. This had been given to the staff for an application they were making, but had since been lost. Some of the files in the office contained old and out of date information. For example, we were examining a file recording people's weights. We asked the staff about a specific person and were told the person had left the service several months previous. Information on staff notice boards was not always current and included information about past events. The lack of organisation around records was a risk that personal information, and personal belongings (such as the freedom passes and driving licence) would be misplaced, taken deliberately or confidential information seen by others.

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

2014

The provider carried out a number of different checks and audits of the service. Not all the audits we were shown at the time of the inspection were up to date. For example, the daily medicines audit was last completed on 18 October 2016, the weekly medicines audit last completed on 14 September 2016 and the monthly medicine audit last completed in August 2016. The provider told us that more recent audits were available but had not been seen at the inspection visit. They said, ''Some of our medication audits were in the other office at the time of the visit and not made available to inspector.'' We also found the monthly bed rail audit was last completed on 28 September 2016. .

We saw that the provider recorded accidents and incidents. The registered manager had undertaken a monthly analysis of these to look at trends. Other audits were up to date, including and infection control audit and care plan audits. Where improvements were needed this had been identified and action had been planned.

People using the service, visitors and staff had mixed views about the service. One visitor said, ''This is not a happy home, the provider is doing the minimum necessary.'' Another visitor told us, ''[My relative] finds it ok here.'' A visiting professional told us they had good experience with the home and that the staff were good at communicating and forthcoming with information. One member of staff told us they were too scared to tell us about their experiences because of their fear of losing their job. Another member of staff told us, ''I feel supported, my manager is good.'' Another staff member said, ''Everything is fine at the moment, it's a nice place to work.''

Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not ensured that service users were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not always acted in accordance with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensured that the premises and equipment used were clean. Regulation 15 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not effectively assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users.

	The registered person had not maintained a secure, accurate and complete record in respect of each service user. The registered person had not maintained securely other records for the management of the regulated activity. Regulation 17 (2)(b), (c) and (d)(ii)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not have all the required information about persons employed at the service as described in Schedule 3. Regulation 19(3)(a) Schedule 3(4) and (7)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that care and treatment to service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have issued a warning notice telling the provider to make the necessary improvements by 31 March 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users because: They had not done all that was reasonably practicable to mitigate risks They had not ensured that the premises were safe. They had not ensured the safe and proper management of medicines. Regulation 12 (1) and (2)(b), (C) and (g)

The enforcement action we took:

We issued a warning notice telling the registered person to make the necessary improvements by 31 January 2017.