Four Seasons (No 7) Limited

Charlton Park Care Home

Inspection report

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Ratings

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

Overall summary

Charlton Park Care Home provides nursing care and support for up to 66 people in Greenwich South London. Following a number of safeguarding concerns raised in June 2014 the local authority placed an embargo on admissions to the home. At the time of this inspection this embargo was still in place and the home was providing care and support to 47 people.

The home did not have 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. The previous registered manager left the home on 30 May 2014. The current manager had worked at the home since 23 June 2014. They had applied to the Care Quality Commission to become the registered manager for the home.

This inspection took place on 29 and 31 December 2014 and was unannounced. We had previously carried out an unannounced inspection on 06 June 2014 following

Summary of findings

concerning information we received. We found that the provider had failed to ensure the welfare and safety of a person using the service and we asked the provider to make some improvements. We inspected the home again on 6 August 2014 following further concerns received and to check if the provider had made any improvements. At the 6 August inspection we asked the provider to take action to make improvements relating to respecting and involving people who use services, care and welfare of people who use services, the management of medicines, assessing and monitoring the quality of service provision and the notification of incidents. The registered provider sent us action plans on 20 October 2014 telling us how they would make these improvements.

At this inspection we found that systems for the management of medicines were not safe and did not protect people using the service. People were not being protected from the risks of inadequate nutrition and dehydration. They were not receiving the food and fluids as recorded in their care plans and as advised by health care professionals. They were not always treated with dignity and respect. People's capacity to give consent had not been assessed in line with the Mental Capacity Act. The provider had not applied for Deprivation of Liberty Safeguards assessments in relation to restrictions placed on people using the service. People using the service were at risk of receiving unsafe or inappropriate care and treatment as accurate records were not always maintained and some staff were not receiving formal supervision or an annual appraisal. You can see what action we told the provider to take at the back of the full version of the report.

We found that some improvements had been made. We tested twenty call bells, all of these were operating. Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms had been fully completed with details of how decisions had been reached. People using the services life stories had been recorded and provided staff with some background knowledge about the person using the service. The provider had recruited more nurses and care staff. The provider had communicated all notifiable incidents to the Care Quality Commission since the last inspection.

Leadership meetings were held each Monday attended by the manager, the area manager and the director of operations. The focus of these meetings was to address the concerns raised in the Care Quality Commission last report and to improve the quality of support for people using the service. A senior manager told us the home faced particular challenges for example improving people using the services dining experience, finding the right staff and creating a positive culture within the home. They assured us that the current management support and leadership meetings would continue until all of the required improvements had been made and all of the concerns raised by the local authorities that commission services had been fully addressed.

We found that the provider had reported safeguarding concerns to the Care Quality Commission and the local authorities as required. Where allegations of abuse had been investigated and substantiated the provider had taken appropriate disciplinary action against staff to protect people using the service. There were five ongoing safeguarding concerns being investigated. We will continue to monitor the outcomes of safeguarding investigations and actions the provider takes to keep people safe.

There were arrangements in place to provide people using the service with a varied programme of activities. People using the service and relatives and we spoke with said they had been consulted about their care and support needs. They told us about regular meetings where staff listened to their views and opinions and they knew how to make a complaint if they needed to. Staff told us that the manager had made a number of changes and improved the culture of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Systems for the management of medicines were not safe and did not protect people using the service. Pain assessments were not always completed for people.

Appropriate recruitment checks took place before staff started work. There were enough staff on shift to meet the needs of people using the service.

Is the service effective?

Inadequate

The service was not effective. People using the service were not being protected from the risks of inadequate nutrition and dehydration. They were not receiving the food and fluids as recorded in their care plans and as advised by health care professionals.

Some staff were not receiving formal supervision or an annual appraisal. This meant that some staff did not have the opportunity to review their roles and discuss their personal development with their line manager.

People's capacity to give consent had not been assessed in line with the Mental Capacity Act.

The provider had not applied for Deprivation of Liberty Safeguards assessments in relation to restrictions placed on people using the service. Therefore people may be subject to unnecessary or unlawful restraint.

Is the service caring?

Requires Improvement

The service was not always caring. People using the service were not always treated with dignity and respect. Adequate support was not being provided to enable people to eat and drink sufficiently.

People using the service and relatives and we spoke with said they had been consulted about their care and support needs.

People were provided with appropriate information about the home in the form of a service user guide. People and their relatives told us about regular meetings where staff listened to their views and opinions.

Is the service responsive?

Requires Improvement

The service was not always responsive. People using the service were at risk of receiving unsafe or inappropriate care and treatment as accurate records were not always maintained.

There were arrangements in place to provide people using the service with a varied programme of activities.

People knew how to make a complaint and the complaints policy was

Summary of findings

available at the service.

Is the service well-led?

The service was not well led. We found that the provider had made some improvements however they had failed to safely support people with their nutritional care needs and risk assessments. They had failed to ensure people were protected against the risks associated with medicines. They had also failed to maintain accurate records in relation to the care and treatment needs of people using the service.

The home did not have a registered manager in post. The current manager had applied to the Care Quality Commission to become the registered manager for the home.

Requires Improvement

Charlton Park Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.This inspection was carried out on the 29 and 30 December 2014.

The inspection team consisted of four inspectors, one of whom was a pharmacy inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including notifications they had sent us and the provider completed 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. After the inspection we contacted an officer from the local authority that commissions services from the provider and a member of the local clinical commissioning group for their views on the service.

We spent time observing the care and support being delivered. We spoke with five people using the service, the relatives of three people, fifteen members of staff, the home manager, the area manager and two of the provider's directors of operations. We looked at records, including the care records of twelve people using the service, four staff members' recruitment and training records and records relating to the management of the service.

Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People using the service told us they felt safe and that staff treated them well. One person said, “I feel safe and I like being here.” A relative of a person using the service said, “I have no complaints about the attitude of staff towards my relative. In the two and a half years I have been coming here I’ve seen nothing to concern me.” However our findings did not indicate that this was a safe service.

At the last inspection on 6 August 2014 we found people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage people’s medicines. We asked the provider to take action to make improvements on how medicines were managed. At this inspection we found the provider had made some improvements however we found that people using the service were still being placed at risk. There was a continued breach of this regulation.

There was a lack of up to date and detailed information regarding the use of some pain medication. Most people were prescribed medicines to be given only when needed (PRN), such as pain relieving medicines. We saw that although protocols had been written after our last inspection to provide staff with some instructions on when to administer these medicines, these protocols had not been updated when people’s medicines were changed. Some of these protocols lacked detail, for example whether the person was able to tell staff when they were in pain or whether staff had to carry out an assessment of people’s pain to decide whether to administer a medicine. This meant that staff did not have up to date guidance on when to administer as required medicines particularly for those people who may be unable to communicate their needs.

We found that the medication administration record (MAR) for one person indicated that medicine for the relief of pain was to be taken four times a day when required. A record of PRN medication had not been completed for this medicine. However there was a record for another PRN which was no longer prescribed. This person had been prescribed another pain relieving medicine, to be given when needed. During the inspection we heard them calling out in pain, saying they had a headache. We looked at this persons care file and saw that a pain assessment and evaluation form had been completed on 6 September and 20 December 2014. This assessment did not record that the person was prone to headaches. This meant that although this person had been prescribed two pain relieving medicines, there was no record that their pain was being assessed regularly which placed them at risk of being left in pain.

Another person’s MAR indicated that medicine for the relief of pain was to be taken three times a day on a regular basis. We saw they had received this medicine regularly three times a day from 8 December to 27 December 2014 however then the stock of this medicine had run out and the person had not received five doses of this pain relieving medicine. A pain assessment and evaluation form had not been completed. This person had been placed at risk of being left in pain because this medicine was not available.

Medicines were not stored securely. We found a single tablet in a white envelope in the medicines trolley for a person using the service with a handwritten instruction of “one hour before test”. This medicine was not listed on the person’s MAR.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service told us they felt safe and that staff treated them well. One person said, “I feel safe and I like being here.” A relative of a person using the service said, “I have no complaints about the attitude of staff towards my relative. In the two and a half years I have been coming here I’ve seen nothing to concern me.” However our findings did not indicate that this was a safe service.

The home had a policy for safeguarding adults from abuse and a copy of the "London Multi Agencies Procedures on Safeguarding Adults from Abuse". The manager was the safeguarding lead for the home. We saw a safeguarding adult’s flow chart that included the contact details of the local authority safeguarding adult’s team. The area manager told us this flow chart provided guidance for staff in reporting safeguarding concerns. Staff demonstrated a clear understanding of the types of abuse that could occur. They told us the signs they would look for, what they would do if they thought someone was at risk of abuse, and who they would report any safeguarding concerns to. One member of staff said, “If I even thought someone was being treated badly I would report that right away to the manager.” Another member of staff said, “I have had my training on safeguarding. If I saw someone being neglected or abused I would report it right away the nurse in charge

Is the service safe?

or the manager. If they didn't do anything I would whistle blow or call the Care Quality Commission." The area manager said they and all staff had received training on safeguarding adults from abuse. The training records we saw confirmed this.

We found that the provider had reported safeguarding concerns to the Care Quality Commission and the local authorities as required. Where allegations of abuse had been investigated and substantiated the provider had taken appropriate disciplinary action against staff to protect people using the service. For example on the 18 October 2014 the manager carried out an unannounced night time check and discovered three members of staff asleep whilst on duty at the home. The organisations disciplinary procedures were followed and all three members of staff's employment at the home were terminated. At the time of this inspection there were five safeguarding concerns being investigated by the home and a local authority. We cannot report on these at the time of this inspection. An officer from one local authority safeguarding team told us the home was making the necessary improvements required and was cooperating with the safeguarding investigations. We will continue to monitor the outcomes of safeguarding investigations and actions the provider takes to keep people safe.

At our last inspection, we had found at least four rooms where call bells were either missing or had not been placed within some people's reach. In two cases the call bell had not functioned when we tested them. This presented a risk to people who would not be able to call for assistance from staff in the event of an emergency. During this inspection we tested twenty call bells and found these all to be in working order. Staff responded quickly to these calls. We saw call bell check records in people's rooms. These had been completed and recorded the call bell was accessible to the person. We spoke with three people using the service who had limited mobility. All said they could call for help using the call bell, and that their call bells worked. One said, "I get help quite quickly, if I call they are always there."

Another person said, "Staff usually answer the call bells quickly but it depends on how busy the staff are." A relative of a person using the service said, "The call bells were answered quite quickly."

There were enough staff on shift to meet the needs of people using the service. At our last inspection we found there were five registered nurse and nine care staff vacancies at the home. Most of these posts were being covered by bank or agency staff. At this inspection the manager told us there was one registered nurse post and three care staff vacancies. Three of the staff we spoke with said they had started working at the home in December, one of whom had started working on the first day we inspected. The manager told us the home was much less reliant on bank and agency staff and they were actively recruiting to fill the vacant posts. A relative of a person using the service said, "My relative needs two carers to support them, staff are evident most of the time." Three members of staff told us there was enough staff on shift to meet people's needs and that if they were short of staff they would inform the manager they would get the staff in.

Appropriate recruitment checks took place before staff started work. We looked at the personnel files of four staff that worked at the home. We saw completed application forms that included references to staff's previous health and social care work experience, their qualifications, their full employment history and explanations for any breaks in employment. Each file included two employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out.

There were arrangements in place to deal with foreseeable emergencies. Staff said they knew what to do in the event of a fire and told us that regular fire drills were carried out. We saw that a fire evacuation procedure was on display throughout the home and records confirming that the fire alarm system was checked by staff on a weekly basis. There was a fire risk assessment in place; this had been reviewed in November 2014. Staff training records confirmed that all staff had completed training on fire safety.

Inadequate

Is the service effective?

Our findings

People using the service and their relatives said they thought the food was good. One person using the service said, "The food is very good and they would do something else for me if I wanted it." Another person said "The food's alright but there is no choice usually." A relative said "The menu is very good and varied. They always get liquid during the day." Another relative said, "Alternative food is available. My relative loves the food here and they get enough to drink." However our observations at the inspection identified concerns about people's nutrition.

When we inspected the home in June 2014 and in August 2014 we found that people were served solid foods which were not part of a pureed diet that had been recommended by health professionals to meet their individual needs. Following our inspection in August 2014 we took enforcement action against the provider for failing to take appropriate steps to ensure people using the service were protected against the risks of inappropriate or unsafe care and treatment. At our inspection on 29 December 2014 we observed staff put a half slice of toast in a person's mouth, although the person made no effort to chew the toast. The person's care plan said they needed a soft diet because they were at risk of choking. We found the guidance available to care staff in the kitchen where meals were served recorded this person should be supported to have a soft diet. Staff removed the toast when our inspector queried the suitability of toast as part of a soft diet. The person's care plan contained additional information from a speech and language professional which said the person should have a soft diet. Adequate support was not being provided to enable people to eat and drink sufficiently.

The provider had developed a prompt "at a glance" sheet to highlight people's care needs in order to ensure they received the correct support from staff and a list of menu requirements for each floor in the home. However these documents contained contradictory for four people. For example, one person had a food and fluid guidance record which said they had issues with swallowing food and required a softer diet. The menu sheet and prompt sheet for care staff recorded this person as requiring a puree diet. The nurse on duty told us the food and fluid guidance was out of date and confirmed the person now required a puree diet. Another person was recorded as requiring a normal diet on the prompt sheet and a notice board in the nurse's office but their care plan recorded swallowing difficulties identified by a speech and language therapist and specified a puree diet was required. There was a risk of people receiving inappropriate food which could present a risk of choking.

Another person who was diabetic was given biscuits and cake with their tea. A member of staff said the person's diabetes was, "Diet controlled and they are not on insulin so it is alright." We looked at this person's care file. We saw an advice sheet relating to diabetes management and a care plan for diabetes. The care plan stated that this person must not have sugary foods. The care plan did not detail what foods the person should eat, the frequency of blood sugar testing or what signs would be present if the person became unwell. The nutritional profile for this person did not record their diabetes and stated they should have a normal diet. There was a risk that this person would not receive suitable food and nutrition to meet their needs.

A person had lost weight and their BMI score had reduced. However their malnutrition risk assessment score had been wrongly calculated and a lower risk score was recorded for this person than should have been. If the correct score had been calculated the person's weight and nutritional risk assessment would have been reassessed in seven days. At the time of our inspection twenty one days after the wrongly calculated score, the risk assessment had not been reviewed. Therefore there was a risk that further weight loss and malnutrition would not be quickly identified and acted on.

We observed people using the service during the lunch time period in the dining rooms. We saw drinks were served with the meal to ensure people remained hydrated throughout lunch. In one lounge we saw three people being served lunch. Two of these people were left without drinks. We saw there was a drinks machine in the lounge; however these people were not able to mobilise sufficiently to get drinks for themselves. Adequate support was not being provided to enable these people to access drinks.

These issues were a breach of Regulation 14 of the Health and Social care Act 2008(Regulated Activities) Regulations 2010. As we have identified a continued breach of regulation we will make sure action is taken. We will report on this when this is complete.

Inadequate

Is the service effective?

People using the service said they felt the care delivered was good. A relative said, “Staff seem to know what they are doing.” Staff said they had completed an induction and received training when they started working at the home. However some staff said they did not receive any supervision or an annual appraisal.

We looked at the supervision records for four members of staff. We found that only one of these staff had received formal supervision in the past year. One member of staff told us they had worked at the home since September 2013 however they had not received any formal supervision or an annual appraisal of their work performance. Another member of staff told us they had worked at the home for five years and had not yet received formal supervision or an annual appraisal with the new manager. This meant that some staff did not have the opportunity to review their roles and discuss their personal development with their line manager.

This was a breach of Regulation 23 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Four staff told us they had shadowed experienced members of staff for up to five days and they had completing training on moving and handling, fire safety, first aid and safeguarding adults. A member of staff told us, “The management consider our requests for training and we get it.” The area manager said e learning was used for some of training however training such as; moving and handling, fall prevention and oral health care were delivered face to face. We looked at staff training records. These showed that most staff had completed training that the provider considered mandatory. This training included basic life support, food hygiene, medicines, manual handling, safeguarding adults, health and safety, infection control, dignity and respect and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We saw evidence that an NHS team had provided targeted training such as blood glucose monitoring for staff in the past year. The manager told us that many of the staff that received that training had since left employment. A member of the NHS team said they planned to meet with the manager in the new year to look at ongoing issues and arrange further training for staff. Following the inspection the manager confirmed that training had been arranged for staff in January 2015.

When we inspected the home in August 2014 we found that a person’s care plan did not include an assessment of their capacity to make decisions for themselves, and there was no record of meetings with the person's family and others to agree decisions in the person's best interests. This meant that the person was at risk of receiving care and treatment they had not agreed to.

During this inspection we found that people had mental capacity assessments in place for some important decisions such as the use of bed rails or decisions around the use of cardio-pulmonary resuscitation. When people lacked capacity to make these decisions we saw that healthcare professionals consulted people’s family members to make decisions in their best interests, in line with the Mental Capacity Act (2005). However we also found some mental capacity assessments in place which were general and said a person lacked capacity to make decisions, without specifying the decision to be made. One person had a care plan in place regarding their rights, consent and capacity. However there was no guidance on the care plan regarding whether the person had been assessed as having capacity to make specific decisions or how they could be supported. There was therefore a risk that people’s capacity to give consent had not been assessed in line with Mental Capacity Act (2005).

We saw that each floor of the home employed key codes to the lifts and exit doors. The manager told us they not applied for Deprivation of Liberty Safeguards assessments in relation to these restrictions. We saw that one person using the service had a stair gate placed at the entrance to their bedroom door. We looked in this person’s care file. We found a completed mental capacity assessment, a risk assessment, a consent form and a best interest’s record for the use of bedrails however there was no information in this persons file in relation to the use of the stair gate. Therefore we found the provider had not followed the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and people may be subject to unnecessary or unlawful restraint.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection we found that Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms had not been fully completed with details of how decisions had been reached. During this inspection we saw that DNAR

Inadequate

Is the service effective?

forms were in place for some people. The forms had been correctly completed and signed by the persons GP. Best interests and mental capacity assessment paperwork had also been completed.

People using the service and their relatives said people were able to see health care professionals when they needed. One person using the service said “The doctor visits weekly and I can see him if I want.” Another person said, “My nails are cut sometimes.” A relative said the GP visits on Fridays and, if we need, other healthcare appointments were arranged. When there were concerns people were referred to appropriate healthcare professionals. We looked at the care files of twelve people using the service. We saw they had been receiving care and treatment from a range of health care professionals such as speech and language therapist, tissue viability nurses, dieticians, chiropodists and dentists. In all of the care plans we looked at we saw that people had been seen by a GP to discuss needs such as weight loss or pain control. Staff told us the GP visited each unit once a week; however they would attend on other days to deal with an emergency if necessary.

Requires Improvement

Is the service caring?

Our findings

People using the service and relatives we spoke with said they had been consulted about their care and support needs. A person using the service said "I can talk to the staff at any time about my care needs." Another person said "The nurses are nice, they are good to me. I don't get any trouble from the girls who work here." Another person said "I like the staff, we get on alright, we help one another, and the staff are very nice." Another person said, "My daughter visits me every day. She can come to see me whenever she wants." A relative said, "The beds are made, the food is good and my relative is well looked after." Another said "On the whole they are doing their best and I think they are doing a good job here. I think the care is good and that's normal every day."

Despite the positive comments from people using the service and relatives some of our observations did not indicate that this was a caring service. For example adequate support was not being provided to enable people to eat and drink sufficiently. We observed, mid-morning, that one person was given a glass of milk, a biscuit and a piece of cake in their room. We saw that these items were still there mid-afternoon not eaten. This person appeared tired and sleepy when their lunch was brought to their room and left. Their care plan identified them as being "severely underweight ", and that they "may need prompting to finish food ". We saw that a member of staff tried to encourage them to eat without success and left the food on the table. No other prompting or encouragement was offered nor was there any alternative food provided. The meal was taken away untouched with the food and fluid recorded offered but refused. We also observed a member of staff place a piece of toast in a person's mouth. The person did not make any attempt to hold the toast themselves and sat in the dining room with toast hanging out of their mouth. This did not show the person as treated with dignity and respect. We discussed this with the senior managers at the home who immediately spoke with the staff concerned.

People using the service and relatives and we spoke with said that staff treated people with dignity and respect. People using the service appeared well dressed. One relative said, "They treat my relative with dignity and respect. They knock on the door and ask if they can come in. They draw the curtains when they are helping my relative to get washed and dressed." Another relative said, "The staff give my relative the privacy and dignity they require and deserve." We observed staff knocking on people's doors before entering their rooms.

Staff told us doors and curtains were always closed prior to providing people with personal care. This was to ensure people's privacy and dignity was respected. One member of staff said, "I never fully undress people when I'm doing their personal care. I make sure that half of them is always covered with a towel. I speak to them throughout to help relax them and ask them for their permission before I do anything."

People were provided with appropriate information about the home in the form of a service user guide. We saw a copy of this in people's bedrooms. The service user guide ensured people were aware of the services and facilities available in the home.

People and their relatives told us about regular residents' meetings where staff listened to their views and opinions and they were able to talk about things that were important to them. The manager told us that residents' meetings took place every three months however the last meeting had been cancelled as senior managers' were not available. We saw the minutes from the last residents' meeting held in August 2014. The meeting was attended by one person using the service, the relatives of eighteen people using the service, the manager and the organisation's senior managers, officers from the local authorities contracts team and the care home support team. Issues discussed at the meeting included a safeguarding investigation, an open surgery for relatives to raise concerns about the home, evening and night time spot checks, the whistle blowing policy and the induction of new staff. Actions from the meeting included activity coordinators and chefs assisting people using the service at meal times, new revised menus, a decoration programme for the kitchen and kitchenette and staff recruitment. We saw that activity coordinators and chefs supported people using the service at meal times during the inspection and that the decoration of the kitchen had been completed. The manager told us that new menus were in place and staff vacancy levels had reduced. Feedback from people at the service was being acted upon.

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us about the care and support they received at the home. One person using the service said, “I can’t get around but I usually get what I want.” A relative said “I think they give my relative the care they need.” Another relative said “My relative is looked after as needed.” However at the inspection we found that staff did not have access to up to date information relating to people’s current needs.

People using the service were being placed at risk of receiving unsafe or inappropriate care and treatment because accurate records were not always maintained. We saw care plans had been recently reviewed to ensure that they met people’s needs. However we found that some people’s care plans did not record sufficient detail relating to their current needs. For example we saw a care plan for self harming; however the care plan did not provide guidance for staff on how to support this person if they self harmed. In another person’s care file we saw two falls were recorded in May and September 2014 however there was no information on record on how these falls occurred. This meant that staff may not have been fully aware of how to reduce the risks of falls happening again. In another person’s care file we found the person was described as being frail and bed bound. Staff told us they knew how and when they needed to support this person with repositioning however there was no recorded guidance in the care plan for staff on how pressure area care should be managed.

Staff told us family members were involved in care plan reviews. We saw evidence in some of the care files we looked at that family member’s had been informed when changes were made to the care given to their relatives. However it was not always evident in care files if family members were present during the review meetings.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people’s life stories were displayed in their bedrooms. This included their place of birth, details of relatives, their career history and their interests and hobbies. This provided staff with some background knowledge of the person using the service. A member of staff showed us the visual aids they used to communicate with people who had dementia. They told us they used these to help people to choose their food and drinks. Another member of staff told us they knew what people’s likes and dislikes were because they had read them in their care plans. We saw that people’s likes and dislikes were recorded in the care plans looked at.

People had summaries of their care needs in a document called ‘This Is Me’. This gave staff guidance on how to support people with personal care, meals, medication and mobility. People’s preferences, including activities they enjoyed and preferences for food and the gender of care staff supporting them with personal care, were also summarised in their care plan. Daily care notes recorded people’s experiences such as enjoying musical activities available in the home. Guidance on supporting people with mobility needs was available in individual bedrooms, and when we spoke with two care staff they were aware of the number of staff required to support people safely.

At our last inspection, we had concerns that entries in daily care records for a person using the service lacked detail and entries were often repeated, for example, "ate and drank well" was recorded on numerous occasions. This presented a risk that the person’s nutritional needs were not being met. At this inspection we checked the care files of twelve people using the service and found more detailed information had been recorded in their daily care records.

There were arrangements in place to provide people using the service with a varied programme of activities and the opportunity to practice their spiritual belief. In the foyer we saw photographs of activities that had recently taken place. These included visiting entertainers and a visit by children from local schools that came to sing carols. We saw an activities coordinator engaging with the people in a sensory room and then later on visiting people who were bed-bound for a chat. The activities coordinator said they enjoyed working at the home and had worked there for six years. They showed us an activities programme which included games such as bingo and ball games, coffee mornings, film screenings, visiting entertainers and animal handlers. They told us about a Nativity play which people using the service enjoyed and staff had joined in. They said the salvation army visited the home two or three times a year and clergymen from local churches visit once a month.

We saw staff giving some people manicures. People responded well to this activity. We observed a social gathering in the bar. Staff were serving people drinks and discussing an old movie, which was being shown. Staff

Requires Improvement

Is the service responsive?

were caring and allowed people to make decisions for themselves. For example we heard a member of staff asking a person using the service, "Would you like your usual drink or do you feel like trying something else today?" We saw that some staff had organised a game of skittles on the ground floor.

People using the service and their relatives said they knew about the home's complaints procedure and they would tell staff or the manager if they were not happy or if they needed to make a complaint. We saw a copy of the complaints procedure was in the service user guide kept in people's rooms. Each person was allocated a key worker and named nurse, details of which were displayed in the bedrooms with details of how to contact them if there were concerns. A person using the service said, "I would complain to one of the staff if I needed to." A relative said, "I have never complained but I could approach the management and they would have resolve it." Another relative said "If I have a query, I go to the management" and "The manager responded to a request from me for more bowls in the dining room." The area manager showed us a file with records of complaints received at the home. These records, included details of the complaints received, the action taken by the home to resolve the complaint. We found that when complaints were raised the responses had been thorough and timely.

Requires Improvement

Is the service well-led?

Our findings

People using the service and their relatives said the manager and staff were approachable. One relative said "I have no reason to think that the management is not good. The home was good enough for my relative." Another said "The housekeeper is very efficient." Another relative said they did not see the manager very often. A person using the service said that staff seemed to work well together. However we found that the provider did not always identify issues which presented a risk to people.

At our last inspection we found that the provider had not implemented an effective system to regularly assess and monitor the quality of service that people received, or to identify and manage risks relating to health, welfare and safety of service users and others. This related to broken call bells, drinks not being placed within reach in their bedrooms and monitoring of people's hydration had not been done.

At this inspection we found that the provider had made improvements in monitoring the quality of service in the area's that we had previously identified. However the systems they had in place had failed to identify shortfalls with peoples nutritional care needs and risk assessments. The provider's medicines audits had not identified the risks associated with medicines to be given only when needed (PRN), such as pain relieving medicines. They had failed to identify that mental capacity assessments were not decision specific and restrictions placed on people were not fully considered. They had not identified that records in relating to peoples care needs had not been accurately maintained.

These issues were a breach of Regulation 10 of the Health and Social care Act 2008(Regulated Activities) Regulations 2010.

At this inspection we saw that regular audits had been completed on health and safety, infection control, medicines and staff recruitment records. We also saw records of regular call bell, bed rail, and pressure mattress and hoist checks. Regular unannounced night time visits were being carried out by the manager. The manager told us about meetings held each Monday morning to discuss any weight loss for people using the service. Where concerns about people losing weight were identified referrals were made to the appropriate health care professionals. However we found that guidance from health care professionals was not being followed as people's nutritional needs were not being met.

We saw records from daily management reports. These were completed following a walk around the home and included observations such as the home being clean and odour free, unrestricted fire exits and staff wearing uniforms and personal protective clothing. The manager told us about "flash meetings" they said these took place daily where they met with nursing and care staff. The focus of these meetings was to communicate the current needs of people using the service for example people's individual health issues such as pressure sores or weight loss. We also saw that issues identified during the managers walk around were discussed at the flash meetings. However we found that staff did not have access to up to date information as records relating to people's current needs were not always maintained.

At our last inspection we found that the provider had not always notified the Care Quality Commission about incidents that had occurred at the home. Our records showed that the provider had communicated all notifiable incidents to the Care Quality Commission since the last inspection.

The home did not have a registered manager in post. The previous registered manager left the home on 30 May 2014. The current manager had worked at the home since 23 June 2014. They were in the process of registering with the Care Quality Commission to become the registered manager for the home. Given the number and nature of the concerns raised at our last two inspections, we, along with the local authorities that commission services from the home, had concerns about the support the manager was receiving from the organisation. We wrote to provider on the 26 November 2014 regarding our continued concerns and about the lack of consistent support for the home manager. The provider responded to us on the 28 November 2014 advising of the actions they were taking to address our concerns, the management arrangements at the home and the support systems that were in place for the manager. At this inspection we noted that area manager attended the home three days a week and a manager from another of the provider's care homes and the director of operations visited once a week.

Requires Improvement

Is the service well-led?

We saw that leadership meetings were held each Monday attended by the manager, the area manager and the director of operations. The manager told us the focus of these meetings was to address the concerns raised in the Care Quality Commission report and to improve the quality of support for people using the service. Records seen from these weekly leadership meetings confirmed that this was the case. The director of operations told us the home faced particular challenges for example improving people using the services dining experience, finding the right staff and creating a positive culture within the home. They assured us that the current management support and leadership meetings would continue until the required improvements had been made and all of the concerns raised by the local authorities that commission services had been fully addressed.

The manager showed us an action plan drawn up by the home following the ongoing safeguarding concerns and the Care Quality Commission's last inspection report. The manager told us they had met with the clinical commissioning group (CCG) to discuss the action plan and the CCG confirmed this. They said the manager had the right attitude; they were open and willing to learn. We spoke with a contracts officer from one of the local authorities that commission services from the provider. They said they had met with the manager and senior management and had agreed to contact with the management team every two weeks to discuss the progress of safeguarding concerns and any other quality issues fed back by local authority staff during visits into the home. They told us suggestions they had made to the provider had been reflected upon and actioned.

The manager told us about the recently developed leadership team. This team consisted of staff designated as leaders in dignity, documentation, activities and dining. We spoke with a member of staff who was a leader in dignity. They told us they had received training on dignity and leadership and it was their role to observe and ensure staff supported people using the service in a dignified manner. If they observed poor practice they would encourage and educate staff to support people in the correct manner. They said. "Being a leader gives me some zeal, I feel motivated to work harder so that people using the service feel better. I feel empowered and part of a team." We were not able to consider the impact of the leadership team on people's care at the time of inspection.

One member of staff told us there had been a high turnover of managers in the last few years. They said they hoped the new manager stayed because they had introduced some good initiatives such as flash meetings and a leadership team. Another member of staff said there had been a change in culture within the home and that staff were listening and learning. There had been improvement in teamwork and on the quality of care provided to people using the service. They said they were well supported by the new manager and the area manager. They told us they found the flash meetings useful as they identified things that needed to be done and they could get on with the job. Another member of staff said the flash meetings encouraged staff to meet people's needs.

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 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 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported to enable them to deliver care and treatment to service users safely and to an appropriate standard.** **Regulation 23(1) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider 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.** **Regulation 18 (1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Accurate records in respect of people using the service were not always maintained. This placed people at risk of receiving unsafe or inappropriate care and treatment.** **Regulation 20 (1) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to implement an effective system to regularly assess and monitor the quality of service that people received, or to identify and manage risks relating to health, welfare and safety of service users and others.

Regulation 10(1)(a)(b)

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider had failed to protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, and safe administration of medicines used for the purposes of the regulated activity.

The enforcement action we took:
We issued a warning notice the provider requiring them to be compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 2 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider had failed to ensure that service users were protected from the risks of inadequate nutrition and dehydration. Service users were receiving the food and fluids as recorded in their care plans and as advised by health care professionals.

The enforcement action we took:
We issued a warning notice to the provider requiring them to be compliant with Regulation 14 (1)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 2 February 2015.