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Willows Care Home

Inspection report

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Date of inspection visit: 30 March and 1 April 2015.
Date of publication: 02/06/2015

Ratings

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

Overall summary

We carried out an unannounced inspection on 16 and 20 October 2014. We found that the provider was in breach of a number of regulations at that time.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified. We undertook a focused inspection on the 30 March and 1 April 2015 to check that they had followed their action plan and to confirm that they had now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Willows Care Home ' on our website at www.cqc.org.uk

The Willows care home is split into two units that support people with conditions associated with old age and disability as well as people living with dementia. The service is registered to accommodate a maximum of 73 people. At the time of our inspection there were 50 people living at the home.

The provider employed a compliance manager to work alongside the home manager who is registered with the Care Quality Commission. 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 2008 and associated Regulations about how the service is run.

Summary of findings

Although people we spoke to and their relatives told us that they were happy living at Willows and that the staff were kind to them, we found that the provider had not completed their action plan confirming that they would meet the legal requirements. We found that there were a number of 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 end of the report.

We found that some improvements were required in order to make the environment safer and better suited to meet the needs of the people living with dementia such as signage and aids orientation. We found that the provider had still not ensured that people were provided with equipment such as call bells and mattresses that met their needs. We found that this equipment was not always properly checked and maintained. The checks that were in place were ineffective.

The provider had begun a consultation with people using the service and their relatives about the safety and security of their rooms. However, people's wishes were not always respected and signs placed on doors did not afford privacy or respect.

Although the provider had ensured that staff had received training in mental capacity and DoLS (Deprivation of Liberty Standards), staff did not understand the implications of this upon their day to day work and how decisions should be made and documented for people who lacked capacity.

The provider had failed again to notify us of significant incidents that had occurred in the home in order to ensure that the people fully protected from the risk of harm. Staff had failed to identify or respond to a number of issues where people had been placed at risk of harm.

People told us that they had the care that they needed and that staff responded appropriately to them. They told us that they felt safe and that care staff usually came to them quickly if they called for help. However, we found that the records kept in order to direct staff in how to provide personalised care were not accurate or complete. This meant there was a risk of inappropriate care being delivered where a staff member did not know the person well.

Although the provider had systems in place to monitor the quality of service, they had once again failed to be effective and identify many of the discrepancies that we found during this visit to the home.

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.

We found that although some action had been taken to improve the safety of the service the provider was still not meeting legal requirements.

People told us that they felt safe and cared for.

Equipment that people required was now provided but measures in place to monitor its use and safety were not robust.

People were placed at risk because their medicines were still not managed safely.

The registered manager did not always adhere to legal obligations and inform the commission where people's safety and welfare had been compromised. They also failed to identify significant concerns and refer them to the local authority for investigation

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service effective?

Inadequate 

The service was not effective.

We found that some action had been taken to improve the effectiveness of the service but the provider was still not meeting legal requirements.

The provider had sought the opinion of people using the service and their families about safety and security of their rooms; however they had not always adhered to people's wishes.

Staff received additional training when required but they did not always demonstrate what they had learnt in their practice.

Staff did not follow the requirements the Mental Capacity Act 2005 for people who lacked capacity to make decisions about their care.

We could not improve the rating for effective from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service responsive?

Requires improvement 

The service was not responsive.

We found that the responsiveness of the service had not improved and the provider was not meeting legal requirements.

Summary of findings

Most people were positive about the care provided by staff but we observed that care was not provided in a timely manner and this caused distress at times.

Records kept were not always accurate or completed in a timely manner. This meant that the care provided may not always be safe or appropriate to the person's needs.

We could not improve the rating for responsive from requiring improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service well-led?

Inadequate

The service was not well led.

We found that action had not been taken to improve the effectiveness of the quality audit systems and people therefore remained at risk.

We found that audits carried out by staff had failed to identify the concerns we found around medication, consent to care and treatment, care planning and equipment.

We found that the service had failed to notify CQC about significant events.

We could not improve the rating for well led from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Willows 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.

We undertook an unannounced focused inspection of Willows on 30 March and 1 April 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 16 and 20 October 2014 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led. This is because the service was not meeting some legal requirements.

The inspection team consisted of two inspectors, a pharmacy inspector, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for somebody who use this type of care service. The expert by experience on this inspection had experience of using services for older people with dementia.

Before the inspection, we reviewed the information that the provider had given us following our last inspection. They had provided with an action plan that gave details of how they were going to make improvements. They had indicated that all of the improvements were to be completed by the time of the inspection.

We also spoke with the local authority quality assurance and safeguarding team. They informed us that they had undertaken two safeguarding investigations since our last inspection but there had been no significant concern as a result of these. We also spoke to the fire service who felt that the provider was cooperating with their requirements for improvement.

During the visit we spoke with nine people who lived at the home, four relatives, five nurses, four care staff, the registered manager and the compliance manager.

We reviewed a range of records relating to people's care and also about how the home was managed. These included the care plan records for nine people and any supplementary information that the home kept in relation to their care. We looked at training and induction records for staff employed at the home. We also looked at maintenance records, medication records, and quality assurance audits that the registered manager, compliance manager and other delegated staff had completed.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Willows Care Home on 16 and 20 October 2014 we found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the provider had failed to notify the commission where serious injury or allegations of abuse had occurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's welfare and safety had been put at risk as a number of people did not have access to a call bell to summons help. This was breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010

A number of people were being cared for on pressure relieving mattresses that were on the wrong setting for the person's weight, were too big for the beds, or damaged. No checks had been carried out to see whether this equipment was in good working order. This was a breach of Regulation 16 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

The provider had commissioned by a fire risk assessment to be carried out in November 2013 and this had identified several concerns. It was not clear whether any of the actions had been addressed and who was responsible. It was deemed that people using the service and others could be put at risk. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We identified a number of issues in relation to the storage and administration of medicines. We also had concerns around the use of covert medication (medication hidden food or drink). This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection, we found that the provider had not followed the action plan they had written to meet all the shortfalls in relation to the legal requirements and there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people that we spoke to on the inspection told us that "Safe, oh yes." "It is safe here" "I'm safe". Their relatives and friends confirmed this view.

Four staff we spoke with demonstrated they understood and were aware of safeguarding issues. They also stated if they had any concerns they would report them to their senior or the manager, or Head Office. All were aware of the whistleblowing procedure. One person also said if they had any issues which were not being dealt with within the organisation they would contact social services.

However, prior to this inspection, we had been informed by the safeguarding team that they had recently investigated two safeguarding referrals. The provider had failed to inform the Care Quality Commission (CQC) about these incidents. The compliance manager and the registered manager told us that they were still unsure as to what to report to us or to the local authority. Their responsibilities were clearly outlined in the relevant CQC and local authority procedures which they had access to.

We found a number of recorded incidents, reviewed by the registered manager that should have been referred to the local authority as safeguarding concerns. This included incidents that had occurred between people using the service. For example a person had pushed a table onto another person's leg and then grabbed it causing injury that required treatment due to bruising and swelling. On another occasion staff had documented that a person had "punched" another person in face.

We also identified concerns that were considered of a safeguarding nature that had not been reported by staff. We found that one person had not received two types of eye drops for fifteen days and these were for a serious eye condition and was not identified in any of the care plans. Staff had recorded that the person had refused to allow them to administer these eye drops but staff had not taken any remedial action or recognised the significant impact that this could have on the person concerned. This was brought to the attention of the registered manager on the day of inspection and urgent action was requested. As a result, a GP visited the next day to review this medication.

The provider had failed to protect people from abuse and improper treatment. They had also failed to ensure that systems and processes operated effectively in order to identify and investigate allegations of abuse.

Inadequate

Is the service safe?

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

At our focused inspection, we found that people were still not protected against the risks associated with the unsafe use and management of medicines

People and their relatives told us that they had their medication when they needed it and that it was reviewed by the visiting GP. However when we looked at the management of medicines for fourteen people who were living in the home, we found concerns about the administration of medicines or the records relating to medicines for all those people.

Some people were given their medicines without a safe time interval between doses. This meant that people were at risk of being given medicines such as Paracetamol unsafely. We saw that medicines which needed to be given 30 to 60 minutes before food were given at the same time as medicines which should have been given with or after meals. Medicines must be given at the correct time in order to make sure they work properly and avoid unnecessary side effects.

We saw that nurses sometimes failed to follow the directions and did not give people their medicines properly. One person had been given more tablets than prescribed on eight separate occasions in the fifteen days. The manager was also investigating an error which had led to another person being given a medicine for nine days, even though the prescriber had ordered it to be stopped. Seven people had not been given their medicines, including tablets, inhalers and eye drops, as often as they should have been. In one case this was because the person was already asleep before the bedtime medicines round. Neither the nurse on duty nor the manager could explain why the medicines were not being given correctly and why these people's medicines had not been reviewed. People were placed at risk of harm because they were not being given their prescribed medicines correctly.

Some people were prescribed medicines to be taken only when required, for example, painkillers. We found there was not enough information available to guide nurses when these medicines should be given and in some cases, where a variable dose was prescribed, how much medicine should be given. For example, one person had been prescribed lorazepam to help with their agitation, but there was no information to help nurses decide when to give this. It is important that this information is recorded and readily available to ensure that people are given their medicines safely, consistently and with regard to their individual needs and preferences. Failing to administer medicines safely and in a way that meets people's needs places the health and wellbeing of people living in the home at risk of harm.

Medicines were stored safely and were locked away securely to ensure that they were not misused. Most medicines could be accounted for as printed records were clear and accurate. However nurses had not always accurately recorded the quantities of medicine received into the home or carried forward from the previous month. This made it impossible to tell how much medication should be present and therefore whether or not these medicines had been given correctly. We saw records that showed that some medicines had been signed for, but had not actually been given, whilst others had been given, but not signed for. There were missing signatures on some records and it was unclear if medicines had been given or not on those occasions. The health of people living in the home is placed at unnecessary risk of harm when medicines records are inaccurate.

We looked at the arrangements in place for four people who were given their medicines covertly; that is hidden in food or drinks without the person's knowledge or consent. Although a policy was in place for determining mental capacity, the assessment tool used did not clearly show whether or not each person understood the implications of refusing their medicines. In one case, no assessment had been completed. Crushing tablets and mixing medicines in food and drink may alter the way in which the medicines work and may make them ineffective or dangerous to use. There was no evidence that a pharmacist had been consulted about the safety of giving the medicines in this way. There was no information in place to tell nurses which medicines were to be given covertly or exactly how and in what circumstances they should be given. There was also concern that people with swallowing difficulties, requiring pureed foods or thickened fluids, were being given whole tablets within it. Another person with a poor appetite had medication in food but staff had not considered what would happen on occasions where a meal had not been eaten. There were no risk assessments in place It was not always possible to see from records which medicines had been given covertly and which had been given with the

person's knowledge and consent. We saw that the tablet crushers in use were very dirty and contaminated with powder from tablets that had been crushed. Failing to keep these devices clean placed people at risk of harm by being given traces of medicines they were not prescribed.

We saw that staff had been issued with the NICE guidance (National Institute for Clinical Excellence) of managing medicines in care homes yet had not implemented any of this into their practice.

The provider was not ensuring the proper and safe management of medicines.

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

At our focused inspection, we found that some improvements had been made towards meeting the regulations**.**

We looked at the records of people, and saw that the staff had completed an assessment for each individual as to whether a call bell was necessary. They had also taken into consideration whether a person could understand its use by carrying out a decision specific mental capacity assessment. One relative told us ""He has a pressure mat now in his room. He couldn't deal with a bell or buzzer." Staff had identified other means by which to monitor some people or the person without a call bell such as implementing regular checks. "No call bell, mum wouldn't know how to use it. She had a pressure pad taken away I don't know why". However, we found that there were no risk assessments in place to demonstrate how the effectiveness of these other measures was to be monitored or reviewed.

We saw that new call bells had been purchased so that one was available for each room. We also saw maintenance records that indicated that they were being checked monthly. Staff we spoke to also told us that "There's a buzzer in every room where they need it and I make sure that it is within reach of the resident", "I put buzzer in hand (resident's) and make sure it's working. "I also make sure the mat is in place." "I plug the mat into the socket and try standing on it to check its working." One relative said their relative had used the call bell following a recent fall and they knew that it was working.

Following our last inspection we raised concerns about fire safety within the home with Cheshire Fire and Rescue service. They visited the service and served the provider with an enforcement notice. They have told us that some progress had been made towards meeting the action plan and this will be reviewed in the forthcoming months. We saw that action had been taken and that staff were aware of changes that had been made to the evacuation plans. We did, note on the day of the inspection, that a number of fire doors were propped open with chairs, four fire doors were not sealing when closed and personal evacuation plans needed to be further reviewed. We highlighted these issues to the registered manager and she agreed to address them with staff.

We saw that there was a monthly analysis carried out by the registered manager of accidents and incidents and actions taken in regards to the risk to an individual. However, no analysis of accidents and incidents was undertaken to highlight emerging themes or trends. We noted that there had been a significant number of un-witnessed falls in communal areas that occurred between 2pm and 8 pm. We asked the registered manager to explore this further as it could indicate a lack of supervision in certain areas of the home.

We had previous concerns about how equipment for people was managed in the home. A number of beds and mattresses had been replaced. The provider had introduced a specific care plan to assist staff in ensuring that mattresses were set at the correct pressures and staff had received training from the manufacturer. However, on the first day of the inspection we saw that seven out of nine care plans did not reflect the correct equipment being used for the person. For example, a person had a care plan and instructions for an air mattress whilst in fact they had a "Propad" overlay mattress on their bed that did not require a pressure setting. We also saw that a number of people had instructions that did not correlate to the mattresses they were using. When we returned on the second day, the provider had ordered new equipment. A staff member had also carried out an audit of all mattresses being used and had placed a copy of the pressure setting required at the foot of each.

The provider had added an additional check to the daily checks carried out: "Air mattress, bed and bumpers are clean and in working order". We spoke to care staff that were responsible for checking mattresses and bumpers but

Inadequate

Is the service safe?

they were not able to tell us what they were checking, or what mattress setting was required. We also saw that the forms were not being completed consistently and sometimes indicated that no checks had taken place.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Willows Care Home on 16 and 20 October 2014 we found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We were concerned that people's freedom within the home had been fully controlled that due consideration had not been given to Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that there were shortfalls in training required for nurses and care staff which put people at risk of receiving ineffective care. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Suitable arrangements were not in place to ensure that staff obtained and acted in accordance with the consent of people in relation to their care and treatment. Unlawful forms of restraint had been used and the provider did not have regard for the Mental capacity act 2005. This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records relating to people and the service were not kept securely and sensitive information was accessible in communal areas. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection, we found that the provider had not followed the action plan they had written to meet all the shortfalls in relation to the legal requirements and there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We highlighted previous concerns in regards to the lack of suitable arrangement to obtain and act in accordance with the consent of service users. At this visit, we found that the provider had not made the necessary improvements.

The registered manager told us that four people received their medication covertly (hidden in food or drink) but we found that one person received their medication in this way. We looked at the care plan records for each person. Nursing staff that we spoke to told us that people's capacity could be variable and so they offered medication on a number of occasions before giving it covertly. However the daily records were not accurate enough to confirm this. Staff were not able tell us what was required in order to give medication covertly in order to comply with the Mental Capacity Act 2005. Care plan documentation for one person stated that they had a "history of being reluctant with medication" and two days after admission, staff had sought the consent of family and the nurse practitioner to administer medication covertly. The daily records and MAR (Medication Administration Records) sheets did not support the need for covert medication as the person was compliant on the majority of occasions. Their care plan for personal care stated that they "Understand what is being said but cannot communicate and find the right words." Covert medication had therefore been given without due consideration of capacity and consent.

Staff told us that they always needed to ask family for consent and felt that "Family would always do the right thing on someone's behalf". We saw that staff had taken instructions from family in regards to key aspects of a person's care "Bedbound due to falls and family wishes", "Must be admitted to hospital if deteriorates on the instruction of [family]" . Staff had sought the consent of relatives for the use of restrictive practices such as bedrails and covert medication without an assessment of the persons own capacity to make that decision. They failed to ensure that there was a best interest decision clearly documented. Staff were not able to tell us if there were circumstances in which family could make a decision on someone's behalf such as when they held a Lasting Power of Attorney for care and welfare. Care plans did not record whether there was someone who held this authority and the registered manager told us she did not ask for copies of the paperwork involved. Therefore, there was a risk that decisions were being made by people without the legal authority to do so.

This means that care and treatment of people was provided with the consent of the relevant person and the provider is not acting in accordance with the MCA 2005 Act.

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

We saw that no progress had been made in terms of dementia friendly signage in the unit for those living with dementia. There was no directional signage to guide

people if they became confused all disorientated. We also saw that there was a sign above the unit for those living with dementia entitled "the dementia unit" that was not dignified and labelling.

We recommend the provider refer to best practice guidance for the development of "dementia friendly" environments.

We found that the provider had made some of the necessary improvements.

The CQC monitor the operation of DoLS which applies to care homes. This is part of the Mental Capacity Act which is designed to protect people who cannot make decisions for themselves or lack the capacity to do so and where their liberty may be restricted. We saw that a number of people who lived at the home had a DoLS in place that had been authorised by the supervisory body (Cheshire West and Chester safeguarding authority) and applications had also been submitted the supervisory body for a number of other people who lived at the home. Staff we spoke to had an understanding of DoLS. They were able to tell us how this impacted the care they were providing for two people as they were authorised to use restraint. The provider also used a "restraint record" so that staff could record when this had taken place for those persons. However, we did note that the "trigger forms" used by the provider to identify those requiring a DoLS assessment did not always provide accurate information and so there was a risk that not all restrictive practices were identified for a person .

At the last visit we found that bedroom doors had previously been locked when people were not inside their rooms. The provider informed us that he had subsequently undertaken a consultation with individuals and/or their representatives to discuss this issue. However, the provider had not documented that they had assessed the persons capacity to make that decision or recorded that it had been made in "their best interest" if they lacked the ability to consent. The provider had also placed a large laminated sign on the front of each person's door to indicate to staff that the person using the service and/or their relatives had requested it to be locked and this did not afford dignity or privacy. We discussed this with the registered manager during the inspection.

People using the service told us that they felt that staff providing care knew "how to do it well" and that "Staff are all trained. They're very good and nice, and always have time for a chat." Relatives that we spoke with told us "Training is probably not enough for anyone, but (they have) a lot more talks since you were here last. ""Old staff seem to know, new staff are (still) learning." Another relative said "There are meetings every Wednesday more than there used to be. I think it is training".

Since the last inspection staff had received training in first aid, Mental Capacity Act 2005, DoLS, and challenging behaviour. Training was also provided around the safe use of bedrails and pressure mattresses. We also saw that the induction pack for new employees had been amended to also include these subjects. A number of the qualified nurses had also been enrolled on additional training around tissue viability and they told us they hoped this would give them the necessary knowledge and skills to be able to provide more effective care to people.

The staff we spoke with all stated they had received adequate training. One person said their induction training had been good and they have since received training in Safeguarding, First Aid, and Manual Handling and pressure care.

Care staff told us that they rarely accessed care plans and did not read them as they were not readily available. However, we saw on both days of the inspection that records were kept securely and locked in offices as per requirements.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Willows Care Home on 16 and 20 October 2014 we found a number of concerns in regards to the responsiveness of the service provided.

We were told that care staff did not always respond in a timely manner or provide the care required. We also saw that the complaints procedure was inaccurate and needing reviewing.

At our focused inspection, we found additional concerns and these were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People using the service told us that the service was responsive. One person said "I' m quite happy, they leave me alone. I don't see much of them, but that's the way I prefer it." However, one relative raised some concerns and we found that staff were not always responsive to people's needs. One relative reported when they had arrived earlier that their relation "had had an accident – all their lower clothing was very wet." The relative said this was very unusual. The person we spoke to said they had called for staff to take them to the toilet when sitting in the lounge after lunch but that they had to wait a long time and "I couldn't help myself. "They were upset we were told it very unlike them. A care assistant had helped them to change their clothes.

We looked at the care records relating to a person who had been admitted seventeen days before the inspection. We saw that staff had not followed the protocol set by the provider that directed staff to complete care plans for new admissions within a week. They were at risk of dehydration and malnutrition yet a care plan and risk assessment had not been formulated. A pressure prevention plan had not been completed despite concerns around the person's skin integrity. This meant that staff would not know what care was required, how best to meet that person's needs and any the preferences that this person had.

We also saw that a person required a diet of a "custard consistency"(should drop easily off a Teaspoon rather than pour) and this was recorded in the care plan. However, we observed that staff assisting them to eat food that did not meet this description and the member of staff when asked did not know the person's dietary requirements. This meant that there was a risk of the person choking or aspirating (food or liquid getting into the lungs) because staff were not following instructions.

We looked at the care plans for a person who had a number of recent falls and found that staff had not carried out all of the neurological observations requested following a hospital admission for a head injury. Accurate and consistent recording of neurological observations is essential to establish the patient's neurological status and to illustrate any changes. As this had not been done, there was a risk that staff would not have quickly identified any deterioration in their condition. Staff had not given consideration to this possibly being a factor in the recent deterioration of the person's behaviour.

The provider had failed to ensure that care and treatment for people was appropriate, met their needs and reflected preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that care plans were not person centred and provided staff with conflicting information about people's needs. They were not updated regularly throughout to reflect changes. We saw, for example, that a person's DoLS trigger form indicated that there were no restrictions in place where in fact the person had a DoLS in place for residence and covert medication.

We saw that some Waterlow scores were not accurate. Waterlow scales are assessments identifying how prone people are to developing pressure sores. One person was classified as obese but only weighed 34 kg. Another indicated an "average appetite" whilst care plans suggested it was poor. Some people required regular checks as they did not have call bells or required assistance to move position in order to prevent pressure sores. The records kept by care staff did not indicate if these checks had been completed. For example: three people required hourly checks but when we checked the records at 1.30pm the last entry was at 11 am. Each person had a "Daily care" record. We found that some of these had not been completed or signed by staff. One record indicated that, a person had not had a hair wash in a month and their mattress had only been checked twice.

Requires improvement

Is the service responsive?

The provider had not ensured that there was a complete, accurate, contemporaneous record in respect of the person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had updated their complaints policy to reflect the recommendation made in the last report. They had also updated their statement of purpose to mirror those changes.

Inadequate

Is the service well-led?

Our findings

On the last inspection we found improvements were needed with the quality audit systems in operation at the home. During this visit we found that the required improvements had not been made.

We found that the quality systems in place were still ineffective as staff had failed address all of the concerns from the previous inspection and failed to the identify issues found on the follow up inspection. This was in relation to care planning, record keeping, medication, equipment, maintenance and consent. For example, an audit of safeguarding had been carried out in February 2015 but it had failed to identify the issues we found during this visit. Both the compliance manager and the registered manager remained unclear on their roles and responsibility for reporting. They also failed to inform us of safeguarding concerns and incidents that had affected the health and wellbeing of persons who used the service in accordance with legislation. Medication audits which had been carried out also failed to identify the concerns highlighted in this report.

The provider did not have up-to- date polices to help and guide staff. This meant that staff were not always providing care in line with current law or best practice guidelines. We looked at the provider's policy on restraint and this had been reviewed in October 2014. However, it was not adequate and did not make any reference to DoLS. It also stated that if decisions are to be made in "best interest" and "families must be in full agreement and that agreement noted". The provider had "consent to examination or treatment policy that made no reference to the Mental Capacity Act 2015. These were not in line with current legislation.

The provider had failed to ensure that systems were in place to assess monitor and improve the quality of the services and therefore mitigate risks. These were a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We saw that the complaints procedure and the statement of purpose had been updated to reflect recommendations in the previous report.

During both days of the focused inspection, we saw that the registered manager took immediate action to bring matters of concerns to the attention of the nurses and care staff. She issued a number of memos and instructions to staff in relation to actions required from the inspection findings.

A meeting involving people using the service was held the day before the inspection as the registered manger had wished to seek their opinion of the care received. It was documented that "People had responded positively about the way that their medication was managed, were happy with the response from staff and felt that "they are known individually by the nurses and this enables them to provide better care". People had expressed their view that" felt that there is not much to do apart from watching television". The registered manager confirmed that there was currently a vacancy for a part time activities coordinator.

The provider had been open and transparent with staff and relatives' following the last inspection and a copy of the report was visible on the notice board and outside the manager's office. Staff told us that they continued to feel supported as they worked together to resolve issues and that she was always approachable.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had failed to ensure that care and treatment for people was appropriate, met their needs and reflected preferences.**

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider has failed to protect people from abuse and improper treatment. They failed to ensure that systems and processes operated effectively in order to identify and investigate allegations of abuse.**

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider has failed to protect people from abuse and improper treatment. They failed to ensure that systems and processes operated effectively in order to identify and investigate allegations of abuse.**

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

The provider was failing to meet the requirements of the Mental Capacity Act 2005 and did not ensure that care and treatment was only provided with the consent of the relevant person.

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that there was a complete, accurate, contemporaneous record in respect of the person. The provider had failed to ensure that systems were in place to assess monitor and improve the quality of the services and therefore mitigate risks to people.

The enforcement action we took:
We issued a warning notice.