Weston Park Care Limited

Weston Park Care Home

Inspection report

Moss Lane
Macclesfield
Cheshire
SK11 7XE

Date of inspection visit:
15 March 2017
19 April 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 15 March and 19 April 2017. The second day of the inspection was delayed due to a vomiting outbreak at the home which meant that inspectors were unable to visit for a second day as planned, but returned on 19 April. Weston Park is registered to provide accommodation and nursing care for up to 118 people. At the time of our inspection, 81 people were using the service. People lived in four separate units, which ranged from general nursing support to specific units for people who were living with dementia. The Tatton Unit had been closed for a number of months but had been re-opened when inspectors visited on day two of the inspection.

A manager was in post but they were not yet 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.

We had previously inspected the home on 12 and 14 July 2016, when it was under a different provider. When the new provider took over the home in September 2016, the deputy manager was subsequently appointed as manager and a number of the staff remained the same. This was our first inspection since the location had been re-registered with us.

At our last inspection, we told the provider to take action to make certain improvements. These included improvements to staffing, safeguarding, consent, good governance and nutrition and hydration. The provider at that time sent us an action plan stating how they would address these issues.

At this inspection, we found that the new provider had started to take action to make improvements but further improvements were still required. We found that improvements were needed to ensure people received consistent support from staff that knew them and their needs well. We also found that improvements were needed to ensure that people received care that was individual to them and responsive to their needs. We had concerns that some people did not have their nutritional needs met safely. People did not always have the opportunity to participate in stimulating activities and we found that people's dignity was compromised at times. There were also issues with the quality assurance systems within the home. Following the first day of the inspection, we asked the provider to send us an immediate action plan to tell us how they would address the concerns we had identified.

We identified seven breaches of the relevant legislation. You can see what action we told the provider to take at the back of the full version of the report.

People's views varied on staffing levels, some said there were sufficient staff whereas others felt that staffing was low at times. We found that staff were not always sufficiently deployed. The home was very dependent upon agency staff. The provider and manager told us that the recruitment of new staff was a high priority

and they were actively recruiting, but that this was dependent upon appropriate applications being received. There had been high staff turnover and the manager told us they were now focused on the quality of the new staff being recruited. A new management structure was being implemented.

Staff spoken with understood what safeguarding was and knew how to report any concerns within the organisation. We found that the home was clean, well decorated and maintained. The maintenance person ensured that all appropriate checks were carried out and recorded.

During the inspection we found that the principles of the Mental Capacity Act 2005 (MCA) had not been followed to ensure people's rights were always protected. MCA assessments had not always been recorded correctly where necessary and DoLS had not been followed robustly enough.

We found that people did not always receive effective care from staff who had the knowledge and skills needed. Information provided for agency staff was inconsistent and at times insufficient to enable them to meet the needs of people. The provider advised us they were working towards supporting the staff to increase their skills and knowledge. Since the new provider had taken over they told us they were addressing staff induction and training.

The provider had undertaken some refurbishment since taking over the home. The Tatton Unit had been refurbished to a high decorative standard and had been re-opened. Many people's rooms were nicely decorated and personalised. There was a maintenance programme in place.

People's views about the food were mixed. Menus had been changed and the provider was focused on making necessary improvements. On the second day of the inspection we found that improvements had been made to the dining experience. However we found that systems for managing people's nutritional risks were not always effective. Staff were not aware of a person's specific dietary requirements which meant that the person could have been at risk of choking.

People living at the home and their visitors gave mixed feedback about how caring the service was. We observed that in some cases staff treated people in a kind manner and had developed effective relationships with them. However also we observed interaction between some staff and people who lived at the home which was not effective. We also found at times that peoples' dignity was compromised. We saw that the management team had already identified areas of practice which needed to be addressed.

Whilst some people told us that staff were responsive to their needs, other feedback received indicated that staff did not always deliver care in a way that was centred around individual needs and preferences. For example concerns were raised about the lack of choice regarding the time a person liked to get up and people's personal care needs not being met.

We identified a number of issues with the records that were maintained for people. We found that some care plans were not detailed enough to provide staff with the information they needed to deliver effective, responsive care. Work was being undertaken to re-write all of the care plans onto new documentation, in consultation with people and their relatives.

We found that some activities were available to people, but these needed to improve. Staff vacancies had impacted on further improvements. The head of activities had developed a work plan since coming into post, which included a proposal about the actions needed to enable people to follow their interests and improve the activities available.

The new owner and regional manager were closely involved with the current management of the home. They told us they had inherited a significant number of issues but were focused on making the necessary improvements to the home. They have developed an action plan and the recruitment of new staff and implementation of a new management structure had been identified as a priority. Staff supervision meetings and staff meetings were being held.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Our records indicated that some notifications had been had submitted notifications to CQC in line with CQC guidelines. However we found that we had not received notifications to inform us about any DoLS authorisations made by the supervisory body and the manager was not aware of her responsibility to submit these.

There were some systems in place to monitor the quality and safety of the service. However, some of the quality assurance systems that the provider had put in place were not sufficiently robust, as they did not identify the concerns that were identified on this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We found that the home was highly dependent upon agency staff. The provider was actively recruiting new staff.

We found that the service was not always safe because staff were not familiar with or knowledgeable about people's individual needs.

Staff spoken with understood what safeguarding was and knew how to report any concerns within the organisation.

There were aspects of risk management that were being managed appropriately, but we found that this was inconsistent.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The requirements of the Mental Capacity Act were not always followed. We found that the DoLS were not implemented consistently.

We were concerned that people's nutritional needs we not always met, because staff lacked knowledge about people's individual requirements.

Staff received training and the provider was developing staff training and induction.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found that people's dignity and privacy had not always been maintained.

We observed some positive and caring interactions between staff

and people who lived at the home.

People told us that staff were kind and they were involved in decisions about their care.

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Is the service responsive?

Inadequate

The service was not consistently responsive.

Some feedback received indicated that staff did not always deliver care in a way that was centred around individual needs and preferences.

There were some activities available but these needed to be developed further to meet people's individual needs.

People and their relatives knew how to make a complaint and raise concerns. However improvements made as a result had not always been sustained.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a manager in place, but they were not yet registered with the CQC.

There were some systems in place to monitor the quality of the service. However, these were not effective because we found areas on this inspection which had not been identified by the systems in place.

Staff told us that the manager was approachable and felt that some improvements had been made since the new provider took over.

CQC had not been notified about all reportable events as required by the legislation.

Weston 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 checked 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 visit took place on 15 March and 19 April 2017 and was unannounced. The inspection team consisted of three inspectors and one 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.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also had feedback from the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan. On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We spoke with 17 people who used the service and 10 relatives and visitors. We also spoke with 13 members of care staff and five nurses, some of these were agency staff. Agency staff are staff who are employed by a separate organisation which provides staff to any service which requires them. We also spoke with the owner of the home, the regional manager, the manager, a unit manager, housekeeper, head of maintenance, clinical trainer and head of activities. Some people were unable to tell us their experience of their life in the home because they were living with dementia, so we observed how the staff interacted with people in communal areas.

We looked at a sample of care files, six in detail and several others in respect of specific issues we had identified with their care. We inspected other documentation related to the day to day management of the service. These records included quality audits, training and induction records, supervision records and maintenance records. We also review three staff files. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedroom.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at Weston Park. People's comments varied. They told us, "Yes I do feel safe here "and "It's safe here, I feel they make me strong." However other comments included "I fell one day and did something to my left leg and then I fell again on it." Relatives spoken with told us "Yes, it's safe here", "Yes, (name) is safe, they got this chair for them specifically" and "Relatively safe, always problems with other residents wandering in as they keep your doors open here."

One person told us that they were concerned because the "emergency button" by their bed and in the bathroom had not been working for a few days. We raised this with the manager who told us that a new call bell had been delivered and was in her office waiting to be installed. She arranged for this to then be fitted straight away, but the person told us in the meantime they had had to bang on the table if they needed assistance

We viewed the rotas, spoke with people and staff and saw that the home was very dependent upon agency staff. The provider and manager told us that the recruitment of new staff was a high priority and they were actively recruiting, but that this was dependent upon appropriate applications being received. There had been high staff turnover and the manager told us they were now focused on the quality of the new staff being recruited.

The provider was in the process of introducing a new management structure, with a view to improving the leadership on each of the separate units. Since the provider had taken over the former deputy manager had taken on the role of home manager. Two new roles had been introduced, including the appointment of a clinical trainer and head of activities. The manager told us that a new deputy manager was due to start and we saw they were undertaking their induction on the second day of the inspection. Two new unit managers for the Mulberry Unit and Weaver Unit had also been recruited. A number of seniors carers were due to start and a nurse was awaiting recruitment checks.

The manager told us that the home was staffed according to the occupancy and dependency of the people living at the home. We saw that each person had an assessment which indicated their level of dependency. The manager told us that these assessments were reviewed regularly and were used to inform the numbers of staff deployed. She explained that she also regularly visited the units to monitor the staffing levels. People views varied on staffing levels, some said there were sufficient staff whereas others felt that staffing was low at times. The majority of staff spoken with felt that the numbers of staff were satisfactory. However one member of staff told us they felt there were times when there was not enough staff especially when agency staff didn't arrive for a shift as planned.

Relative's comments included "(Name) is totally immobile and it takes two people to move them… there is a wait, it takes a period of time. They are trying to do their best"; "(Name) can't walk and needs hoisting, this means a delay to go to the toilet, possibly a long wait" and "I don't wait long, once I call the bell."

We found that staff were not always deployed sufficiently to meet individual needs. We spent time in the

lounge within the Silk unit and observed a member of staff (who was working elsewhere within the home) inform an agency member of staff that the lounge should never be left unattended. We observed on at least two occasions that the lounge was left unattended by staff and for at least ten minutes on one occasion. We discussed this with the member of staff who told us that they knew the lounge should not be left unattended but because they were the only carer available and someone needed support elsewhere, they could not supervise the lounge as well. One carer was on a break and the nurse was occupied in a meeting.

People and staff told us that the use of agency staff did impact the care provision as they were not always as familiar with people's needs. Relatives' comments included "Agency staff don't know the residents, they are not used to them" and "There's a lot of temp staff and when you ask them for something, they are only here one day." A member of staff told us "At times, it doesn't always feel safe, not because of the numbers but because they don't know people."

We noted concerns about the skill mix of staff especially on the Silk Unit. This was because on the first day of the inspection all four staff on the unit were provided by an agency. The manager said that although there was a high usage of agency staff, it was very unusual for there to be no permanent staff on duty and that regular agency staff were used to support continuity where possible. However, staff spoken with reported difficulties in meeting people's needs on the day of the inspection, because there was no permanent member of staff available on the unit to offer support. Two staff had been transferred from another unit and had not been party to the handover. They had some information about the people they were supporting, for example an agency member of staff was able to tell us about the changes to a person's mobility needs and how best to support them. However we also found that staff did not have the correct understanding about a person's diet and fluid requirements. The person's care plan had been very recently reviewed and changed to say the person required a soft diet and thickened fluids. However, the nurse we spoke with was unaware of this. Therefore we found that staff did not have sufficient knowledge of people's need to meet them in a safe manner.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always provided in a safe way.

The manager told us that they carried out checks before new staff started to work to ensure they were suitable to care for and support people using the service. Staff records checked included an application form, proof of identity, two references and a Disclosure and Barring Service (DBS) criminal records check. The provider had undertaken an audit of all of the staff files to ensure that appropriate checks had been carried out prior to them taking over as provider. There were five staff where a DBS check could not be evidenced and we were assured that this was being addressed.

Staff spoken with understood what safeguarding was and knew how to report any concerns within the organisation. We saw that the home had both a safeguarding and whistleblowing policy. The manager demonstrated that they understood their responsibility to identify and report any suspicion of abuse. The manager kept a safeguarding file which contained local safeguarding procedures and information about any safeguarding referrals that had been made.

Whilst we saw that people had risk assessments in place, we saw that actions identified to reduce risk were not always being followed by the staff. For example one person was assessed as being at high risk of falls. The person's care plan recorded that they had fallen and following another fall a few hours later were taken to A & E due to a head injury. We found that the person's falls risk assessment and mobility care plans had not been reviewed following the fall. The care plan stated that the person needed close supervision at all times and could not be left unattended. We observed that the person was in the lounge during the

inspection and there were no staff present for at least 25 minutes. We spoke with a member of staff who told us that the lounge should be supervised when there were "walkers" in the lounge and that this person had not mobilised since her fall. However, we found that the person's risk assessments had not been appropriately reviewed.

There were aspects of risk management that were being managed appropriately. Moving and handling risk assessments were in place and changes implemented where necessary. Other assessments included the risk of pressure ulcers and those at risk of malnutrition. There was a procedure in place to monitor incidents and accidents. We saw from the records that accidents and incidents were recorded and reviewed by the manager. Any action could then be considered regarding the prevention of these risks in future. Whilst there was a monthly record of the incidents and accidents, there was no detailed analysis to help identify any themes of trends. The regional manager acknowledged that they needed to develop this analysis further.

We looked at how medicines were managed in the home. On Weaver unit nurses wore tabards to indicate that they were undertaking a medicines round and should not be disturbed unless absolutely necessary, to reduce the risk of mistakes and allow them to concentrate on that task. We saw that most people had a photograph on their medicine administration record (MAR) to assist new or agency staff in identifying them. All staff had been required to record specimen signatures and the medicine policy was available.

We sampled 14 MARs and found that all had been completed accurately. Medicines were counted and recorded on receipt into the home. We could see that staff had signed the record each time a medicine designed to be taken orally had been administered and the records tallied with the stock balance. We checked the records and stock for controlled drugs (those that are liable to misuse and need stricter controls) and found that these were being stored, administered and recorded safely. The management team had recently undertaken a full audit of the medications on the Weaver Unit.

We did see however that the system for recording the application of topical creams and ointments was not robust. The unit manager told us that there had been charts in people's rooms for the care staff to record when they administered creams but she had removed them because they were not accurate and staff were forgetting to maintain the records.

Charts were available for staff to record the temperature of the treatment room and medicines fridge. However from records for the month of April up until the day of the inspection (18th) no entry had been recorded on 10 days. On the days when the temperatures had been recorded the range varied from 24-28°C. The majority of medicines are required to be stored in temperatures below 25°C. Storing medicines outside of this range leads to a risk that the medicines will not be as effective. The provider was aware of the issue with the temperatures and demonstrated that action was being taken so that the temperatures could be controlled effectively.

The home employed a maintenance team. We spoke with the head of maintenance and reviewed their records, which demonstrated that regular checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. We were advised that the new provider had inherited a number of historical issues and had now resolved a pest control issue. Checks undertaken included fire safety systems, call bells, water temperatures and equipment. Appliances were also regularly serviced. Risk assessments were in place for the premises, environment and use of equipment to ensure risks were kept to a minimum. Fire Marshall training was planned, we saw that some fire drills had been undertaken but the regional manager informed us that the frequency of these would be increased. Personal emergency evacuation plans [PEEPs] had now been completed for people to help ensure effective evacuation of the home in case of an emergency.

The building was clean and we saw that there was a team of domestic staff who were working hard to ensure that the environment remained clean. We noted that a few concerns had been raised within some resident surveys about the cleanliness of the building. We spoke with the head housekeeper and asked about cleaning schedules and whether there was a programme of deep cleaning in place. The new provider had not yet implemented documentation regarding cleaning schedules and these were awaited by the staff. There were also some vacancies within the domestic staff team which we were told impacted on the team's ability to undertaken deep cleaning. We discussed this with the provider who told us that they were aware of the issues and had plans in place to implement schedules and recruit new staff.

Requires Improvement

Is the service effective?

Our findings

We asked people living at Weston Park whether they found the care and support to be effective. Most people spoken with told us that they found that the care provided was effective. One person said "In general they are quite good." Relatives told us staff were "generally well trained and caring" and "Even with turnover of staff, yes they do seem to insist on certain standards." Someone else commented "I think things have got better."

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

We found the provider was not consistently working within the principles of the MCA. Staff spoken with had varied knowledge about the MCA. Some were able to demonstrate a good understanding, while others were unable to tell us how the Act impacted on their day to day work. We saw from the training matrix that a number of staff had undertaken training but a large proportion of staff including the manager had not completed this training. We saw that all staff had been asked to complete this training by the end of May 2017.

People told us that that staff sought consent before they provided care and involved family and friends in decision making where appropriate. They said "They (staff) involve the family in making decisions" and "They ask for consent, sometimes I ask to be left alone if need be."

Where people did not have the capacity to make decisions these were made in people's best interest. We saw that capacity assessments and best interest decisions were recorded in a number of cases. However, even though people had capacity assessments, these assessments were not always decision specific and therefore did not meet the requirements of the MCA. For example one assessment viewed suggested that the staff member who had undertaken the assessment lacked understanding about the requirements. They had simply stated that the person was unable to retain information and had not specifically recorded the decision being made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that some people had DoLS authorisations in place and there were a number of others where applications had been made to the supervisory body for an assessment. However we found that the systems for recording this information were ineffective. The manager had some records but was unable to provide definitive information regarding the people who had authorisations in place and when these were due to expire. We saw on the first day of the inspection that there were some people who due to the nature of the

care being provided needed to be assessed under DoLS. The manager told us that she was in the process of making the necessary applications.

We found from discussions with the manager that she would benefit from further training around the MCA and DoLS procedures. Indeed, following the inspection we were informed by the local authority that the provider had breached the MCA as one person's DoLS authorisation had expired and a request for a new authorisation had not been submitted in time. This meant that we could not be certain that people's rights were always being protected.

These issues were a breach of Regulation 11 of the Health and Social Care Act (2008) Regulated Activities (2014) Regulations.

We looked at the arrangements for eating and drinking. People's views about the food were mixed. On the second day of the inspection we saw that new menus had been introduced and there was a choice of food available each day. Staff told us that if people didn't like the food on the menu then alternatives could be offered. Comments about the food included, "It's quite reasonable, not fantastic"; "Food is served hot from a trolley but limited choice" and "It could be good but the plates are always cold and the food is cold by the time you get it." One person who was vegetarian confirmed they were offered a suitable diet that met their preferences. A relative told us that the food seemed to have improved since the new provider had taken over.

On the first day of the inspection we observed lunchtime on the Mulberry unit and found it to be quite disorganised. Some people were kept waiting for a long periods of time and food had gone cold by the time staff supported at least one person with their meal. Staff advised us that the lack of sufficient crockery and cutlery caused a delay in serving some people. On the second day we saw that new crockery and cutlery had been purchased. The manager told us that improvements to the meal time experience were being implemented. Hot trolleys had also been purchased so that food could be served and a new kitchen steward role had been introduced. This member of staff would serve the food and improve its presentation, as well as serving drinks during the morning. One carer spoken with told us that the changes had meant they had more time to spend supporting people with their meals.

We observed the lunchtime period on the Weaver unit and saw that when the meal arrived, staff offered people a choice of the two main meals, both of which looked appetising and nutritious. Staff were seen assisting people in a kind and respectful way, taking their time and chatting to people whilst they ate their lunch. Pureed diets were presented with each food item pureed separately and piped on the plate so that it looked attractive to eat.

We checked the charts in people's rooms which staff used to monitor people's food and fluid intake. In general we found these were completed contemporaneously and provided an accurate record of people's dietary intake.

However, we had concerns about how nutritional risks were being managed for some people. We could see that two people had lost approximately 5kgs each between January and April 2017. Both these people had Malnutrition Universal Screening Tool (MUST) assessments that identified they had lost weight and indicated that their care plans had been updated to advise staff what action should be taken. However, when we checked the care plans for these people they had not been updated. Another person had put on a significant amount of weight over the previous year but staff had failed to recognise that this potentially put the person's health at risk and had not taken any action to discuss this with them and find out how they felt about it.

On the first day, we saw that one person had a care plan in place which stated they required a soft moist diet and thickened fluids following a speech and language therapy (SALT) assessment several months earlier. The care plans also stated that the person should be supervised when eating. On two occasions during the morning of the inspection the inspector observed that the person was not given a soft diet, but was served cornflakes, eggs, bacon and toast and ate unsupervised in her bedroom. When the inspector asked two members of staff about the person's nutritional requirements they told us that the person required a normal diet. We also asked the agency nurse on duty who was not aware that the person had any specialist requirements. We asked the manager to raise a safeguarding concern with the local authority as the person's care plan and risk management plan had not been followed, which meant that the person could have been at risk of choking. The manager told us that the person's needs had probably changed since this advice was given and a review was required. However she put immediate actions in place to ensure that all staff were aware of the person's requirements and ensured information was included on the handover.

These issues were a breach of Regulation 14 of the Health and Social Care Act (2008) Regulated Activities (2014) Regulations. People nutritional needs were not being met effectively. This was also a further breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities (2014) Regulations, as safe care and treatment was not being provided.

When we returned on the second day of the inspection, we found that staff spoken with were able to tell us about people's dietary requirements in more detail and were able to demonstrate that information was accessible within the units which indicated whether people had any specialist requirements.

We found that people did not always receive effective care from staff who had the knowledge and skills needed. Information provided for agency staff was inconsistent and at times insufficient to enable them to meet the needs of people. The handover sheets we viewed provided minimal information. However, a nurse told us that a new handover document was being introduced which would include more detailed and relevant information for staff. A carer told us that they received information in handover at each shift but that this was difficult if the nurse was also from an agency. Staff on another unit commented that they found that communication wasn't good and they didn't always get the information needed at handover. We saw an example of this when staff on the Silk unit were unable to provide clear information about the consistency of fluids that two people required and who required support with a bath or shower.

The provider advised us they were working towards supporting the staff to increase their skills and knowledge. Since the new provider had taken over they were addressing staff induction and training. The newly appointed clinical trainer planned to work closely with the management team and told us that she had already started to work on staff induction, to ensure in future it met the requirements of the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. There was a current induction plan in place and newly recruited staff spoken with told us that they had undergone a period of induction which included the shadowing of more experienced staff.

The provider demonstrated that an electronic record of staff training was being maintained. This had been updated to confirm which training staff had undertaken and highlighted when training was next due. Some staff told us that they had received training whilst other told us that it had been a while since they had completed any training. We were advised there had been a push on staff to complete electronic training in subjects which the provider considered mandatory. Training included, safeguarding, manual handling, equality and diversity, infection control, MCA and Dols amongst other subjects. We saw on the day of the inspection that training was being undertaken to enable staff to train other staff members in manual handling. The head of activities also told us that the home was working towards becoming a dementia

friendly home and many staff had undertaken dementia friends' awareness sessions.

Staff spoken with told us that they received supervision from the management team, although the consistency of these varied. The regional manager explained that all staff required an appraisal, but that the management team were working through to ensure that all staff had received a one to one supervision session. We saw that a supervision matrix tracker was in place for the next twelve months.

Records maintained showed staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's needs. We saw that people had access to their GP, district nurses and other specialist such as audiology when this was required. We saw that referrals had been made to health professionals such as dieticians and speech and language therapists where necessary.

The provider had undertaken some refurbishment since taking over the home. The Tatton Unit had been refurbished to a high decorative standard and had been re-opened. Many people's rooms were nicely decorated and personalised. There was a maintenance programme in place. We spoke with the head of maintenance for the provider who told us about the extensive work which had been undertaken over the past few months. This included changes to the reception area and laundry. New mattresses and other equipment had also been purchased throughout the home.

Requires Improvement

Is the service caring?

Our findings

People living at the home and their visitors gave mixed feedback about how caring the service was. People told us "It seems very tolerable" and "I think things have got better". Relatives comments included, "Most of them are caring and compassionate, some treat (name) extremely well" and "From what I have seen they are kind and compassionate." However, other comments included "I like some staff and dislike others" and "Majority (of staff) are excellent, a couple of staff are in the wrong job."

One person told us that whilst most staff were "very good"; some of the staff were unable to communicate with them very well because English was not their first language. Additionally this person told us that staff were constantly rushed – "as soon as one (of the staff) comes in, another's at the door telling them they've got to go somewhere else."

We observed the lunchtime period on the Weaver unit. People were brought to the dining area at 12.20pm but lunch was not served until 1pm. Whilst everyone was waiting for lunch to come staff were enjoying a chat and some banter with people. A lively discussion took place about politics and the forthcoming election which had just been announced. Where people needed help to eat their meal, staff sat with each person and took their time offering encouragement and chatting with them. One person on the newly re-opened Tatton unit told us that the staff had been kind and commented "They told me if I need anything just ring the buzzer. I buzzed once at night and they brought me a cup of tea."

However we observed interaction between some staff and people who lived at the home which was not effective. For example, one person suffered a fall and the agency nurse attended them. It was clear that neither the person nor the nurse understood each other but the nurse did not make a real attempt to communicate and the inspector had to intervene to ensure the person had their nurse call bell and explain to them that they needed to ring it for staff to help them if they needed to get up.

The majority of regular staff spoken with were aware of people's needs and preferences. We saw that the care plans in place contained some information about individual likes and dislikes. For example whether people preferred to have a bath or shower or the type of food they enjoyed. Some also contained a "Map of Life" which had been completed to include information about the persons' life history. However, people told us that there were often different members of staff and the high usage of agency staff which impacted on how well the staff knew people. A relative told us, "They keep changing the staff, we don't know them."

We found that some people had been involved with their care planning and making decisions about their care. One person on the Tatton Unit said "When I first came they asked a lot of questions and they did the care plans." The senior staff member who had written the person's care plan explained that the person had been able to say "exactly what her care needs were" and these had been written down. Another person said "I have been asked about my care when I first came here, I generally speak to the manager regarding my needs."

We saw that three compliments had been received about the service since the beginning of the year, one of

these thanked staff for a birthday party that had been arranged for their relative and said "The staff were fantastic."

We saw people's privacy and dignity was maintained in some cases but that this required further improvement. Some staff spoken with knew the importance of treating people with dignity and we observed for example that staff knocked on people's doors before they entered. A new member of staff told us "You give people choice and treat people as you would want to be treated."

However, we saw other examples where people's privacy and dignity had been compromised. Whilst seated in the lounge in the Silk unit we observed a carer discuss information about a sensitive matter with another carer, which did not maintain the person's privacy or dignity. We saw that people's appearance and grooming was not always satisfactory. One relative explained that they were unhappy because "Today when I came (Name) was missing their socks, vest and had not had a shave." We also observed on the Silk unit that one person was seated in the lounge and when they stood up their trousers were far too big and were falling down. When a carer noticed this they supported the person to change, however this had not been identified appropriately to ensure that the person's dignity was maintained.

Therefore the provider had not ensured that people were always treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw from staff meeting minutes that the subject of dignity had been identified by the management team as an area in need of improvement. The standard of care provided to people was an area the management team explained they were focused on improving and that they were taking steps to address this through the appropriate supervision and training of staff.

Relatives told us that staff were welcoming and they were able to visit at any times with no restrictions in place. They said "There are never any restrictions, even mealtimes. We can sit in the dining room and encourage them to eat."

Inadequate

Is the service responsive?

Our findings

We spoke with people living in the home and their visitors about whether they felt staff responded to their needs. Relatives comments included, "It's very tailored to their needs," and "Yes, I do think so, they are always willing to listen."

Some feedback we received indicated that staff did not always deliver care in a way that was centred around individual needs and preferences. For example, one person told us that on a number of occasions staff had got them up as early as 6am. This was against their wishes but staff had said they did not have enough staff in the morning to enable them to assist people if they wanted to get up later.

Throughout the inspection we noted that staff were not always very quick to respond to people shouting for help, for example we heard one person shouting for approximately 20 minutes and staff only attended them when we stood at the door of the person's room to check what was happening. Once staff had attended to the person and moved them to a more comfortable position they were settled for the rest of the morning. During breakfast time we observed that one person was sat at the table but his chair was facing away and he was dozing off, staff did keep calling over to him to encourage him to eat. A member of staff eventually came over and supported him to re-position his chair so that he could actually see his food, at which point he began to eat without any difficultly. However he had not received responsive support in a timely manner.

Some people also told us that their (or their relatives) personal care needs were not always met. For example one person told us that they had not been assisted to clean their teeth for several weeks and we also observed that their teeth and nails looked in need of attention. A visitor also told us their relative did not receive mouth care frequently and when they looked for equipment to assist their relative themselves, there was often no equipment available in their room, and despite asking for some to be provided, there was still none several days later.

This issue was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always ensured that people received person centred care.

We identified a number of issues with the records that were maintained for people. We found that some care plans were not detailed enough to provide staff with the information they needed to deliver effective, responsive care. For example, we could see in one person's care file that they had been assessed at high risk of pressure ulcers but their care plan only stated that they needed "assistance to move and transfer on a regular basis." This did not provide staff with enough instruction as to how often pressure relief was required and we observed that the person sat in a chair all day from breakfast without being assisted to change position. We also found that some care plans had not been reviewed regularly even when people's needs had changed, and care plans had not always been written for key elements of people's care needs, such as pain management, skin integrity and medication.

We saw that a visiting nurse had left feedback on the day of the inspection for the provider to ask them to

ensure that a person's care plan accurately reflected their needs. The feedback stated that information needed to be added, including cognition, communication and psychological needs. We spoke with the nurse who told us that the quality of documents needed to be improved and that daily notes were not always reflective of the care plans. We were told by a relative that a meeting planned for their relative that day had been postponed because of the poor quality of the records. We noted that due to the high number of agency and new staff it was of particular importance that all care plans were current and accurate.

Suitable arrangements were not in place for recording information about people's care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they had already identified the need to improve documentation and had plans in place re-write all of the care plans onto new documentation. During the second day of the inspection we spoke to one of the new unit managers who said that since coming into post, they had focused on updating and reviewing all of the care plans on their unit. The provider had employed a new clinical trainer who had been in post for two weeks and whose role was to address the quality of the documentation and care plans. She had developed a care plan "template" using the new provider's own documentation, to help support staff to understand the standards required moving forward. The owner explained that they were arranging review meetings with people and their relatives to ensure they were part of the care planning process.

We had concerns that staff were not always proactive in seeking out and considering new ways of providing care to some people and as a consequence there was a risk that people's quality of life was not maximised. There was no key worker system operating on the Weaver unit at the time of the inspection and this was discussed with the senior management team, as there were several people whose care needs could potentially be met more effectively if staff could develop trusting relationships with them.

We asked people how they spent their day and whether there were activities going on in the home that they could participate in if they chose to. One person told us that after breakfast he sat in a chair in the lounge area and did not move again from that chair all day. We asked further about this and the person told us that they were unable to move from the chair because they needed the hoist – "I just sit here for the rest of the day." We observed this to be the case on the day of the inspection. Other people were positive about the activities available. One relative said staff did cooking with their relative and other activities such as singing and entertainment. They told us "The entertainment is quite good." Other comments included "The staff sometimes fetch me out to watch events" and "I like the singers."

However, from our observations and discussions with people and staff we found that the activities needed to improve. During the inspection we noticed that there were no activities taking part throughout the morning on the Silk Unit, we saw people sitting in the lounge with little interaction taking place. One person told us "It gets a bit boring." There was an activity taking place within the Mulberry unit where two staff members were supporting four people to make peppermint creams, but little other activities were taking place elsewhere in the home. Entertainment had been arranged for later in the day but unfortunately the performer did not arrive as planned.

We spoke with the head of activities who had been recruited since the last inspection. They told us that the number of staff responsible for activities had recently reduced to two and they were currently recruiting for another two members of staff. The size and layout of the home meant that several staff were required to respond to individuals' needs. The head of activities had developed a work plan since coming into post, which included a proposal about the actions needed to enable people to follow their interests and improve the activities available. Planning a relevant timetable of activities to include group and one to one activities

and to complete life histories for each person living at the home had been proposed. However, the development of this was dependent upon appropriate staff being available to deliver the objectives. We discussed this with the provider who told us that this was being addressed, as part of the home's action plan.

The head of activities had also developed a newsletter for the home, which we saw provided information to people and their relatives about activities on offer that month, including church services and baking/crafts every other week. The letter also informed people that a residents' meeting was due to be held for any resident to join. These meetings had recently been introduced to enable people and their relatives to express their views and make suggestions about the running of the home. Information had also been produced which demonstrated some activities people had taken part in the previous month including a pamper day, art and bingo.

The provider had a complaints procedure in place, which was on display in the reception at the home. People said that they felt able to raise any concerns with staff. They said "Yes, there used to be a nurse in charge I would go to, different people now, so I go to the manager to speak to instead," and "I feel comfortable to raise things." One relative told us that a nurse had been very helpful when they had to raise an issue.

However, one person told us that they had complained because staff had come to get them up too early in the morning on a number of occasions. Following their complaint they had been able to get up later for a few days but on the morning of our inspection staff had reverted to asking this person to get up very early again. This meant that whilst complaints may be initially addressed, improvements were not always sustained.

We saw that the manager had a file in place where any complaint received was documented. There was a log which indicated that the provider had received 14 complaints since November 2016. Whilst we saw that complaints had been recorded, in some cases it was unclear how the provider had dealt with the complaints, although the log indicated that they had been "completed". We raised this with the regional manager who told us that they were aware of this issue and planned to implement a more detailed log which would enable them to monitor progress and evidence how all complaints had been dealt with in future.

Requires Improvement

Is the service well-led?

Our findings

We asked people living at the home and their visitors if they felt the home was well led, comments included, "The manager is very visible, they are always at the front desk" and "The manager is very approachable and they know all the residents." However, one visitor expressed frustration with the many changes of management and senior staff within the home and told us that communication was sometimes lacking. For example, concerns they had raised with previous staff about their relative and agreements reached about their care had to be explained again when new staff started because the information was not properly documented.

Weston Park had been taken over by Weston Park Ltd, under the brand of Capital Care in September 2016. An inspection had been undertaken prior to this in July 2016 where a number of concerns had been identified and improvements to the provision of care were required. The former deputy manager was now the home manager. At this inspection, the manager had not yet registered with The Care Quality Commission (CQC) but was in the process of applying to be registered. The new owner and regional manager were closely involved with the current management of the home. They told us they had inherited a significant number of issues but were focused on making the necessary improvements to the home. They have developed an action plan and the recruitment of new staff and implementation of a new management structure had been identified as a priority.

Cheshire East Council's (CEC) quality assurance and contracts team have been supporting Weston Park to make improvements and have been monitoring their progress against an action plan with regular visits. Recent feedback from CEC confirmed that they had found that the provider was making progress towards these improvements.

We spent time with the home manager and found that she could benefit from further training to improve her knowledge and understanding in certain areas such as the MCA and DoLS. However, we found her to be receptive to any suggestions or recommendations made to improve practice. Throughout the inspection we asked to see documentation, not all of the documentation was clear and organised. The management team were in the process of developing systems and organising some of the records. For example the manager was creating a system to record any DoLS applications. We found that further improvements were required to ensure that all complaints and safeguarding incidents were fully logged and any action taken recorded appropriately.

There were some systems in place to monitor the quality of the service. We saw that audits had been undertaken including catering, beds, infection control, pressure ulcers and medication. We saw that the regional manager undertook an audit on a monthly basis which covered a number of areas. However, the systems were not effective because we found areas on this inspection which had not been highlighted by the systems in place. We have identified a number of breaches to the relevant regulations, with regards to consent, safe care and treatment, dignity and respect, nutrition, person centred care and notifications.

These issues were a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. The systems in place were not robust enough to effectively to monitor, review and improve the quality of care.

Staff told us that the manager was approachable and felt they could raise concerns with her. Staff told us that there had been some improvements in the home since the new provider had taken over, for example equipment had been purchased and CCTV had been installed in the communal areas of the home. Staff told us that the new unit manager on Weaver unit was excellent. They told us she was very approachable and would help them deliver care when needed. The new unit manager had introduced a new system of work which staff felt was much more organised. The agency nurse told us they had been given enough information at the start of the shift to understand what people's care needs were and showed us a handover sheet they had been given with basic information on about people's moving and handling and dietary needs.

Records demonstrated that staff meetings had been held in January and February 2017. We saw the minutes from these meetings which evidenced that a number of areas were discussed and the manager had given guidance to staff about good practice.

We saw that the provider had sought the views of people and their relatives through a questionnaire. Feedback for the questionnaires had highlighted some themes regarding the activities on offer and lack of visibility of the home manager. We noted that four of the relatives spoken also told us they did not know who the manager was. We saw that the manager's office was in the main reception area and had an open door policy; she told us that she had now implemented "manager's surgeries" so that visitors and relatives would know she was available at that time and were welcome to speak with her about any issues. Residents and relative meeting had also been held and subjects such as food and activities were discussed. Comments received included "Since we had new owners, we are asked for feedback on different things" and "I am aware of the relatives meetings they hold, but don't go."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC check that appropriate action had been taken. Our records indicated that some notifications had been had submitted notifications to CQC in line with CQC guidelines. However we found that we had not received any notifications to inform us about any DoLS authorisations made by the supervisory body and the manager was not aware of her responsibility to submit these.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications had not always been submitted to the CQC as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not always ensured that people received person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always cared for in a way that maintained their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the MCA were not consistently met and we could not be sure that people's rights were always protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provide had not ensured that people always received safe care and treatment.

Treatment of disease, disorder or injury

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found that people's nutritional needs were not always being met safely and effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not robust enough to effectively to monitor, review and improve the quality of care. Suitable arrangements were not in place to for recording information about people's care and treatment.