Just Global Ltd

St Paul's Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on 22 and 24 July and 12 August 2015 and was unannounced. At the last inspection on 21 and 30 October 2014 we found five breaches in regulations which related to consent, medicines, recruitment, person-centred care and quality assurance. We requested an action plan from the provider detailing how improvements would be made but did not receive one. At this inspection we found some improvements had been made however we identified further breaches in regulation.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

St Paul's Lodge provides personal care for up to 21 older people living with dementia. There were 19 people using the service on the first day we inspected and 20 people on the second day. Accommodation is provided on three floors, there are single and shared rooms and some have en-suite facilities. There are three communal areas on the ground floor including a dining room.

The home had a registered manager who left on 1 June 2015. A new manager started in post on this date and was present during this inspection. A registered manager is a

Summary of findings

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 found although some improvements had been made to medicines management significant concerns remained. We could not be sure some people had received their prescribed medicines as records were incomplete. We found arrangements for the cold storage of medicines were not safe. We found some medicines were being administered by staff who had not received medicine training. We made a safeguarding referral in relation to one person's medicines, although the issues were addressed by the manager immediately when we brought it to their attention. We found further shortfalls in how medicines were managed when we returned on the third day.

People told us they felt safe. Yet we found risks to people's health and safety were not appropriately managed, particularly in relation to people identified at risk of falling. We found there were not enough staff to meet people's needs and keep them safe.

Although staff had been trained and had a good understanding of safeguarding we found issues we identified relating to medicines and weight loss had not been identified as safeguarding or picked up and rectified by the provider or manager. We also found on the third day of our visit that other safeguarding incidents had not been identified or reported.

People told us they enjoyed the food and we saw people could help themselves to drinks throughout the day. However, people who were of a low weight were not always receiving the nutritious type of food and drink they required and there were not adequate systems in place to monitor people's food and fluid intake or weight.

We found the service was meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff told us they received the induction, training and support they needed to carry out their roles although we found records to evidence staff training were incomplete. Staff had a good understanding of people's needs, yet care records lacked specific detail which put people at risk of receiving inconsistent or unsafe care. We saw people had access to healthcare services such as GPs and district nurses.

There were plenty of activities for people who spent time in the communal areas and we saw people enjoyed playing games, singing and watching DVDs. However, for people who choose to stay in their rooms there was a lack of activity provision.

We saw people had good relationships with the staff and the manager led by example checking with people to make sure they were okay and overseeing the care being delivered. People generally spoke highly of the staff and we observed some kind and caring interactions. However, some relatives raised issues about the lack of privacy and respect. People knew how to make a complaint and we saw complaints were dealt with appropriately.

We found the new manager had brought about improvements in the service, which was confirmed in feedback we received from relatives, staff and a district nurse who visited the home regularly. They told us the home was now cleaner, people looked smarter and better cared for and the manager was 'on top' of things. We found the manager had a good understanding of the improvements that needed to be made. They had already started to address some issues such as arranging training updates for staff and arranging for contractors to visit to make improvements to the environment. However, when we returned on the third day we identified further concerns which reduced our confidence in the assurances the manager had provided.

Overall we found significant shortfalls in the care and service provided to people as well as the continued lack of robust quality assurance systems, which had been identified as an issue at the last inspection in October 2014. We found that issues we identified during the visit had not been picked up by the provider or manager.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment (including medicines), good governance, safeguarding, nutrition, staffing and person-centred care. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Following

Summary of findings

our inspection the local authority reviewed its position regarding its commissioning arrangements with the home. The provider worked with the local authority to move people to alternative accommodation.

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.

Although people told us they felt safe, risks to people's health, safety and welfare were not adequately assessed and managed.

Omissions in the administering and recording of medicines posed risks to people's health and safety.

Staffing levels were not sufficient to ensure safe care.

Is the service effective?

Requires improvement 

The service was not always effective.

People told us they enjoyed the food, yet we found people's nutritional needs were not always met.

Staff told us they received the induction, training and support they needed to ensure they could meet people's needs, however this was not evidenced in the training matrix. People had access to healthcare services.

Improvements were needed in the environment to make it easier for people living with dementia to find their way around the home.

Is the service caring?

Requires improvement 

The service was not always caring.

Although people generally spoke highly of the staff, people's privacy, dignity and respect was not always promoted or maintained.

Is the service responsive?

Inadequate 

The service was not always responsive.

Care plans and assessments did not provide sufficient detail to ensure people received appropriate and consistent care.

People enjoyed the group activities but there was a lack of provision for people who chose to stay in their rooms.

People knew how to make a complaint and complaints received were dealt with appropriately

Is the service well-led?

Inadequate 

The service was not well led.

Although the new manager had started to make improvements breaches of regulations remained. The lack of quality assurance systems and audits which we identified at the last inspection, had not been addressed.

St Paul's Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 24 July and 12 August 2015 and was unannounced. On the first day one inspector and an expert by experience with experience in dementia care visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day one inspector visited. On the third day two inspectors visited the home to gather further evidence.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted commissioners from the local authority and the local authority safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We spoke with six people who were living in the home, four relatives, three care staff, the cook, the activity co-ordinator, the manager and the providers. We also spoke with a healthcare professional who was visiting the home during our inspection.

We looked at three people's care records in detail and others to follow up on specific information, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At the previous inspection in October 2014 we found a regulatory breach in relation to medicines as people did not always receive their medicines in a timely way and there was no guidance for staff about how and when to administer 'as required' medicines. At this inspection we found, although some improvements had been made, significant risks remained to people who used the service.

We saw one person's medicine administration record (MAR) showed they were prescribed Warfarin 3mgs daily, yet there were no signatures to show this had been given on two days. There were no stock levels recorded which meant we could not establish if the person had received the Warfarin as prescribed. There was no blood test (INR) result recorded on the MAR and when we asked the manager about this they told us the district nurses carried out the blood test at the home and they were informed of the INR result by telephone. There was no written confirmation of the INR although the manager told us they had requested this from the GP surgery. The National Institute for Health and Care Excellence (NICE) guidelines: Managing medicines in care homes, states staff should ensure any change to a prescription by telephone is supported in writing before the first or next dose is given. We looked at the person's daily records and saw the Warfarin dosage had been increased two days previously. The MAR had not been updated which meant the person had not received the correct dosage of Warfarin. We advised the manager to contact the person's GP immediately to inform them of the medicine error and to confirm the correct Warfarin dosage, which they did. Failure to administer this medication as prescribed could have had a significant impact on the person's health and wellbeing. We were particularly concerned that the omissions and incorrect dosage were not identified or addressed by the manager or staff until we brought them to their attention. Due to the level of concern identified in this case, we made a safeguarding referral to the local authority safeguarding team.

We saw another person was prescribed a medicine on an 'as required' basis to help them sleep at night. This medicine was a controlled drug. The controlled drug register showed the medicine had been administered on seven occasions since 11 July 2015, yet the MAR had not been signed on any of these occasions. We checked the stock levels of this medicine with the manager and found there was one less tablet than recorded in the controlled drug register. When we returned on the third day of our inspection we found further inaccuracies in the controlled drugs records, which showed stock levels were not being appropriately monitored.

We found the MARs showed two people were not receiving the dietary supplements they had been prescribed. One person was prescribed a supplement twice a day and the MAR showed they had received this correctly for the first three days, had it once on the next two days and had none since 20 July 2015. This was of particular concern as the person was of low weight and at high risk of developing pressure ulcers.

We found a number of gaps on the MARs where medicines had not been signed as given. For example, one person had been prescribed a five day course of antibiotics, which the MAR showed had been given over an eight day period. The MAR showed one day where there were no signatures for this medicine. Another person's MAR had not been signed on 21 July 2015 for the morning medicines prescribed, although when we checked the stock we found these had been given. The senior care staff member told us a new staff member was responsible for these errors and they were going to speak them about it. However we were concerned this had not been addressed sooner as at least one of these omissions had occurred seven days previously.

The manager told us only the senior care staff administered medicines and said they had all received medicines training, which was confirmed by the senior staff we spoke with during the visit. The manager told us there were no senior staff working on night duty, yet records showed and staff confirmed, that the night staff were administering medicines to people. This put people at risk from staff who were untrained in medicines and did not have the skills, knowledge and competencies to handle medicines safely. We discussed this with the manager who immediately put measures in place to ensure that appropriately trained staff administered night medication.

We found there were no records to show what medicines had been ordered, which meant staff were not able to check medicine deliveries to ensure the right medicines and quantities had been received. The medicines fridge was empty and the senior care staff member told us there were no medicines that currently required cold storage. However, we found the fridge was not fit for purpose as it

could not be locked and there was no temperature gauge to ensure the correct temperature was maintained. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we had found there was no guidance for 'as required' medicine. We saw this had been put in place for most of these medicines. Although some supplements and one person's night medication did not have a protocol in place. We also found that staff were aware of people who needed to have their medicines 30 minutes to one hour before food and arrangements were in place for this to happen. We found a copy of the NICE medicines guidelines was kept with the medicines trolley so staff had access, which had not been the case at the previous visit.

Although people told us they felt safe in the home and relatives we spoke with said they had no concerns about safety, we found health and safety risks to people were not always safely managed. We saw two people had recently been hospitalised following falls. We found risk assessments and care plans around the management of falls did not fully consider people's safety or show what options had been considered to reduce the risks. We found there were no environmental risk assessments and no arrangements in place to analyse accident and incidents. This meant hazards and trends were not always identified and addressed to ensure necessary action had been taken to keep people safe and prevent a reoccurrence. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had received safeguarding training and had a good understanding of safeguarding. They said they would have no hesitation in reporting any concerns to senior staff and were aware of whistleblowing procedures. The manager was aware of their responsibilities under safeguarding and knew the reporting procedures. However, we found the service had not done enough to protect people from harm. At the inspection, we identified a number of risks to people that we judged constituted abuse. This included omissions in key medication, and a lack of evidence of documented action following weight loss. These risks should have been identified and rectified by the provider through systems to ensure people were safe from harm. On the third day of our inspection we found further evidence which showed two safeguarding incidents had not been reported or dealt with appropriately. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager how staffing levels were calculated. The manager said people's dependencies were assessed and that they planned to use this information to determine the staffing levels but there was no tool in place currently. Staff told us they felt there were sufficient staff to meet people's needs. However, one person and a relative we spoke with felt there were not always enough staff. They said, "I like living here I feel safe, but we could do with some more staff." A relative told us, "Sometimes there are not enough staff."

The manager told us there were usually three care staff on duty between 7am and 8pm and during the week there was also an activity co-ordinator who worked from 9am until 4pm. One staff member told us it was sometimes difficult at weekends as during the week the activity co-ordinator stayed in the communal areas with people, but at the weekend this was managed by the care staff. We observed that there were long periods of time when there were no care staff in the communal areas.

The cook told us they left at 2pm which meant the care staff had to prepare, serve and clear up the tea time meal as well as providing care. The home employs one domestic who was on leave when we inspected, which meant on the first day of our inspection one of the care staff was also carrying out cleaning tasks. On the second day an additional care staff member had been brought in to clean. The manager told us the call bell system could not be heard in some areas of the home, which they said they had raised with the provider. Yet there had been no review of the risks this presented to people's safety or action taken to mitigate those risks such as increasing the staffing levels. We considered the staffing levels were insufficient taking into consideration the occupancy level, people's needs, the failures of the call bell system and the layout of the building. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in October 2014 we found safe recruitment procedures were not being followed as staff had started work before criminal record checks and references had been completed. At this inspection we looked at files for three recently recruited staff and found

Inadequate

Is the service safe?

these checks had been completed before staff began their employment. However, we found there was no application form for one person and for another there was no record to show gaps in employment and a disclosure on their criminal record check had been explored. We discussed this with the manager who acknowledged the shortfalls and stated they would be addressed. When we returned on the third day of our inspection we reviewed another staff member's file and found discrepancies in the information recorded which meant we could not establish if safe recruitment practices had been followed. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked round the building and inspected some people's bedrooms, bathrooms and various communal living spaces. We found some areas of the home were not clean and noted odours. Door handles, dining chairs and some table surfaces were sticky. On the second day additional staff had been brought in to clean the home. During our inspection in October 2014 we found some areas of the home were in need of refurbishment and redecoration and we were told by the registered manager that this would be completed as part of a refurbishment programme. During this inspection, we found there was still work to be done to bring the premises up to a high standard. We saw the windows on the first floor were unrestricted which meant they could open fully which posed a risk to people. The manager told us there were no environmental risk assessments but they were planning to put these in place. We saw where some over bed lights had been replaced the area around the light had not been plastered and decorated. Our discussions with the manager showed they had already identified these issues and were working with the providers to put an improvement programme together. The manager told us they had also arranged for the fire officer to visit to carry out an inspection and had arranged a meeting with a company who supplied alarm systems. They told us the provider had agreed to the installation of a new call bell system as the current one could not be heard in all areas of the home. We saw maintenance certificates were in place for both chair lifts and the hoist. We saw certificates confirming safety checks had been completed for gas installation, electrical installation, fire appliances and alarms, legionella and boiler maintenance.

Requires improvement

Is the service effective?

Our findings

We found people's nutritional needs were not always being met and dietetic advice was not being followed. For example, we saw one person was a very low weight and had been identified as at high risk of malnutrition. The care records showed the person had been seen by the dietician who had advised they were to have a high calorie diet and to be offered regular fortified meals and snacks as well as supplements. However, our discussions with the cook showed they were not aware of this person's dietary requirements. They said they were not offering the person snacks and were not fortifying their meals. We also found this person was not always receiving their supplements and staff had recorded on the medication administration chart over three days that they were not required. There was no explanation to show why staff had made this decision. There were no food charts in place to monitor this person's food intake. The manager told us they had spoken with the district nurse about the person's weight and when we went back on the second day food charts had been put in place and the manager had instructed staff to give the prescribed supplements. Due to concerns we had about this person, we made a safeguarding referral to the local authority.

We saw menus were planned on a four week rota with one main meal at lunchtime, although the cook told us alternatives were available and we saw these were offered to people. The cook was aware of people's individual likes and dislikes and could tell us who was on special diets such as those who were vegetarian or diabetic. However, there were no records of this information. The cook told us a new cook was working at the weekend who did not have this information and would therefore have to rely on asking the care staff. This meant there was a risk people may not receive the food they preferred or required for diet reasons. The cook told us snacks were not offered with mid-morning drinks as people would not eat their lunch and only biscuits were offered with mid-afternoon drinks. The cook told us they used tinned soups rather than making home-made soup which meant there was a missed opportunity to provide a more nutritious and high calorie meal. This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with said the food was very good. One person said, "I only eat certain foods and the staff respect this and get me what I want." We observed lunch and the food looked hot and appetising. We saw people were offered hot and cold drinks with their meal. We saw one staff member taking their time to support one person with their meal explaining what the food was and gently promoting them to eat. We saw people were able to help themselves to drinks in the dining room throughout the day.

Staff told us they received appropriate training. New staff told us about their induction which included a period of shadowing more experienced staff. The manager told us new staff were working their way through the Care Certificate standards, which was confirmed by a staff member we spoke with. The training matrix showed staff had received training in a range of subjects which included moving and handling, fire safety, infection control, safeguarding, health and safety and food hygiene. However, we saw there were a number of gaps on the matrix and we could not be assured that all staff had received the training they required. The manager told us many of the staff required training updates and since coming into post they had been taking action to address this. For example, senior staff had recently undertaken medicine training with the supplying pharmacist, three staff had signed up to complete a vocational training qualification in care and six staff were enrolled on an equality and diversity course. The manager told us they were organising further dementia training for staff. Staff confirmed they received regular supervision and appraisal and we saw evidence of this in the computerised records we reviewed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation is used to protect people who may have their liberty restricted to keep them safe but are not able to make informed decisions on their own. At the time of our inspection in October 2014 no authorised DoLS were in place nor had any applications being made by the managing authority. At this inspection, we discussed DoLS with the manager who demonstrated a good understanding of their responsibilities and knew how to contact the supervisory body to enable them to seek guidance where necessary. The manager told us two people currently had DoLS authorisations in place and four other authorisations had

Requires improvement

Is the service effective?

been sought from the supervising body but had not yet been received. We looked at the DoLS authorisation for one person and saw records of a recent best interest meeting. We also saw the care records for another person showed they did not require authorisation to deprive them of liberties as they had capacity to make decisions for themselves.

People told us their consent was sought before any support or care was provided. One person said, "I do have a lot of contact with the staff. They come and chat to me, if they have to perform a task they ask me for my consent."

We saw the computerised care records identified people who had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions in place. We asked the manager how staff would know which people had a DNACPR decision in place and were told the only way staff would know would be by staff accessing the information for each individual on the computerised system. This meant that in an emergency staff did not have easy access to critical information about resuscitation decisions. When we visited on the second day the manager told us this information was now included in the verbal and written staff handover.

At the previous inspection there were delays in staff contacting healthcare professionals for advice. At this visit we saw people had access to healthcare services and records showed input from GPs, district nurses, opticians, chiropodists and dieticians. We spoke with a district nurse who was visiting the home during our inspection. They told us they visited the home frequently and felt senior staff were good at contacting them when people needed their input. They said there had been problems in the past with staff not following advice but felt there had been a great improvement since the new manager started in post.

The organisation's website states the home provides specialist dementia care, yet we found many areas of the environment needed improvement to promote the independence of people living with dementia. For example, we saw the lighting throughout the home was low meaning hallways and rooms were dimly lit which national guidance shows can have a negative effect on people living with dementia. We saw some signage was in place but this was minimal. The manager told us they had carried out an environmental audit which had identified these and other improvements. They told us they had ordered new signage designed for people living with dementia and the provider was looking at ways to improve the lighting throughout the home. The manager said a refurbishment programme was planned which would incorporate best practice guidance regarding people living with dementia.

We recommend that the service explores published guidance such as the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia under Quality Standard 30 (QS30: Supporting people to live well with dementia) and Quality Statement 7 (design and adaptation of housing) on how premises can be designed or adapted in a way that helps people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety.

Requires improvement

Is the service caring?

Our findings

Most people spoke positively about the staff and described them as good. One person said, “The staff come and talk to me when they have time and they listen to me, which is nice.” Another person said, “I like living here.” Another person said, “It’s quite homely here. The staff put themselves out to do anything for you.” A further person said, “The staff are good, they look after me alright.” Two people told us, “(The activity organiser) is very caring he goes out if his way to get things for us.”

We observed care in the communal areas of the home on both days of the inspection. We saw people looked clean and well groomed. We saw staff were caring, kind and compassionate with people and this caring attitude came across in the discussions we had with staff who talked warmly about the people who used the service and knew them well. We saw the manager promoted these values by regularly checking with people that they were okay and behaved in a manner which demonstrated they genuinely cared about the people who used the service.

However, we observed inconsistencies in practices in relation to people’s dignity, respect and privacy. For example, we saw staff respected and followed one person’s wishes in refusing us entry to their bedroom as the person had said that due to their culture they did not want any visitors to go into their room. Yet on another occasion we found a soiled incontinence pad and underwear had been left in a person’s bedroom in the morning and was still there when we went back four hours later. Staff told us they checked on this person every two hours yet the soiled items had not been removed.

We saw that the communal areas were busy with people throughout the day and there was a lack of private areas for people to spend time alone or to meet with their visitors other than their bedrooms. One relative told us, “There is no privacy here. Once I came and went into the bedroom to have some privacy with my (relative) and the staff kept coming in and out all the time as if we should not be alone together. I was very upset.” We raised this with the manager and providers who said this should not have happened and said they would address this with staff.

We received mixed feedback from relatives. Some relatives were happy with the care provided. One relative told us, “My (relative) has been here a few years. I think the home is very good. I know she’s safe here.” Another relative said, “My (relative) feels very safe here and so do I, she has improved since she came in here. They encourage her to be independent. ”

Other relatives raised issues about the care which they felt needed to improve. For example, one relative said, “Staff are not trained in looking after people with dementia and sometimes they can be a bit patronising and they do not treat people with dignity and respect.” Another relative said, **“**There is no interactions with the residents and we have not seen a lot of drinks going around when we are here”. A further relative said, “My (relative) has moved rooms lots of times and no one has given their consent for them to do this.” When we discussed this with the providers they told us consent had been gained but did not provide us with evidence to confirm this.

Inadequate

Is the service responsive?

Our findings

We found the service was not responsive in fully assessing people's needs and delivering appropriate care which met people's needs.

We found examples of people's needs not being fully assessed. For example, we asked to see the pre-admission assessment for one person and the manager was unable to locate it, although this was produced on the third day of our visit. There was no pre-admission assessment for another person, although there was typed information which had been supplied by the care service they had been transferred from. This showed the person had a past history of falls and outlined the equipment used to minimise the risk of injury such as hip protectors and a sensor mat. None of this equipment was referred to in the person's care plan, although the manager told us a sensor mat was in place. The falls risk assessment did not give an accurate score as some sections had not been completed. The manager told us no hip protectors had been sent with the person when they transferred, but there had been no action taken to address this.

We found that some of the care plans did not contain the required level of detail to ensure appropriate care. For example, the dietary care plan for one person who was assessed as at high risk of malnutrition just said, 'Enjoys varied diet. Staff to be aware of likes/dislikes and offer choice of meals'. There were no specific goals around eating or what snacks and meals the person required to maintain a healthy weight. Another person's care plan for falls provided general rather than specific information about how to keep the person safe. The care plan said, 'Staff to be aware when (the person) is mobile. Encourage (the person) to seek assistance if they feel unsteady. Remind (the person) to ask for assistance if they ever needed it'. This person was living with dementia and had a history of falls. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed this person's daily records from 1 March 2015 to 23 July 2015 which showed the person had sustained sixteen falls during this period. This was not reflected in the accident and incident reports we reviewed which recorded only two falls for this person during this timeframe. The risk assessments and care plans for this person did not reflect the high incidence of falls or show what action was being taken to reduce the risk of falling and keep the person safe. This meant this person was placed at significant risk of harm due to a failure to assess, monitor and deliver appropriate care and support. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employs an activity organiser who works 9am until 4pm Monday to Friday. During both days of the inspection we saw people in the communal areas enjoying a variety of activities. We saw people watching DVDs, playing games, singing and joining in with quizzes. There was a lot of laughter and people looked bright and alert. We saw one person was doing a jigsaw puzzle and another was enjoying colouring. One person told us how they had been involved in filling pots with flowers for the garden. We saw people were able to walk freely round the home and were not restricted. We saw two people enjoyed sitting outside. At lunch time the activity organiser had their meal with people in the dining room and we saw people chatting and laughing with them.

Two people told us, "We like talking about the war and singing the songs to it and (the activity co-ordinator) comes in with uniforms and medals. We like to talk about local history and what we did when we were young, it's good."

We spoke with the activity organiser who was very enthusiastic about their role. They were able to tell us people's likes and dislikes with regard to activities and said they adapted the activities they provided accordingly. The district nurse who visited the home regularly praised the activity organiser and described them as the 'life and soul' of the home.

However, although we saw people who were in the communal areas benefitted from the activities provided, we found there was no provision for people who choose to spend time in their rooms. The activity person told us they did not go to people who stayed in their rooms and only provided activities to people in the communal areas. We found the focus was on group activity provision rather than looking at how individual interests could be met. One person told us, "I have done aromatherapy and I can do hand massage I would love to be able to do this here but no one has taken the time to find that out about me ".

People and relatives we spoke with knew how to make a complaint. One person said, "If there was anything wrong here I would tell the manager and my daughter. I know how

Inadequate

Is the service responsive?

to make a complaint". There was a complaints procedure which included the contact details for the Commission and the ombudsman. We saw there had been three complaints recorded since the last inspection. Records showed the complaints had been investigated and responded to appropriately. On the first day of our inspection one person told us they had raised a complaint with the provider. On the second day of our inspection the manager told us they had met with this person and were investigating the concerns they had raised.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in October 2014 we found a regulatory breach in relation to good governance as there was a lack of quality assurance systems. We had requested an action plan from the provider to show how improvements were going to be made but this had not been received. At this inspection we found similar concerns.

The home had a registered manager who left on 1 June 2015 and a new manager started in post on that date. The new manager told us they would be applying for registration with the Commission. The manager told us they had sent out a letter to all the relatives introducing themselves and had sent surveys with the letter. They told us they had also given surveys to people who used the service, staff and healthcare professionals and were waiting for these to be sent back. We saw minutes of staff meetings the manager had held and the manager said they were planning to have a relatives and residents meeting very soon. We found many of the people and relatives we spoke with during the inspection told us they did not know who the manager was.

Staff spoke highly of the new manager who they described as supportive. One staff member said, "I've a lot of faith in (manager). The home is much cleaner now, training's getting better and staff are much happier." Another staff member said, "Things are better organised now. (The manager) works on the floor with us." A further staff member said, "She's (the manager) got good ideas and it's all for the residents which is how it should be."

The district nurse told us they had seen improvements since the new manager started and felt the manager was 'on top of things'. They said they had noticed that people looked cleaner and better cared for than they had done previously.

A relative noted improvements but also felt that communication still needed to improve. They told us, "The home has improved recently and the standard of care is better now, ninety percent of the time my dad is clean. But we do not get any information as regards my father's care, he recently had to go in to hospital and the paramedics were very annoyed because there were no medicine sheets so no one knew what medication my father was on."

We found the manager had started to make improvements in the service and had a good understanding of the systems which needed to be put in place to ensure continued improvement. The manager had undertaken some recent audits of the environment and medicines and told us of other audits they were planning to introduce. However, the manager was unable to provide us with evidence to show that any other quality audits had been completed since the last inspection in October 2014, other than some audits of the kitchen. The manager told us there were no systems in place to collate or analyse accidents and incidents, which meant there was no process to identify trends or look at how risks could be reduced and share lessons learnt. We saw the manager struggled to locate information we requested as the office was disorganised and chaotic.

We were concerned that many of the issues we identified at this inspection which presented risks to people using the service had not been identified or addressed by the provider or manager and this was still the case when we visited on the third day. This was of particular concern as the same observation was made at the last inspection in October 2014.

Our report shows people were not receiving their prescribed medicines, medicine records were inaccurate or not completed and untrained staff were administering medicines. Medicines had been identified as a breach at the last inspection and significant concerns remained. Care plans and assessments were unreliable as they contained insufficient detail or inaccurate information, which led to risks to people's health safety and well being. Systems were not in place to ensure people nutritional needs were met. Staff recruitment was a breach at the previous inspection and there remained concerns. Although criminal record checks and references were now being obtained, we found no application form for one staff member, no evidence of exploration of gaps in employment or a disclosure for another and discrepancies in the records for a third staff member. There were no environmental risk assessments and risks to people's safety such as the lack of a fully operational call bell system had not been identified or addressed. Safeguarding issues had not been identified, reported or addressed. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

We found notifications in relation to two people who had sustained serious injuries had not been submitted to the Commission as required. This was a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not provided care and treatment in a safe way for service users as they had not assessed the risks to the health and safety of service users or done all that was reasonably practical to mitigate any such risks. The registered person had not provided care and treatment in a safe way for service users as they had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not protected service users from abuse or improper treatment as systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person had not ensured the nutritional and hydration needs of service users were met as they had not ensured service users received suitable and nutritious food and hydration adequate to sustain life and good health and dietary supplements prescribed by a health care professional. Regulation 14 (1) (4) (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured suitably qualified, skilled and experienced persons were deployed to meet people's needs. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured that the care and treatment of service users was appropriate and met their needs as they had not assessed service users' needs or designed care to ensure their needs were met. Regulation 9 (1) (a) (b) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Recruitment procedures were not established and operated effectively to ensure that persons employed for the purposes of carrying on a regulated activity are of good character.

Regulation 19 (1) (2) (a).